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Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER
THE UNIVERSITY OF MICHIGAN

OCTOBER 1959
Vol. 5 No. 10

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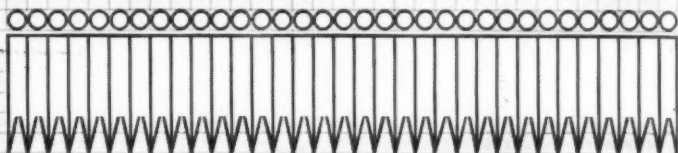
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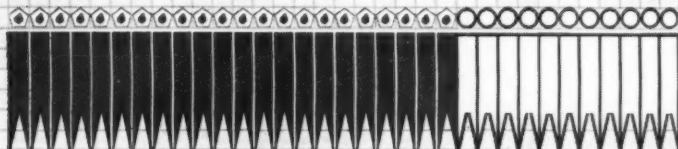
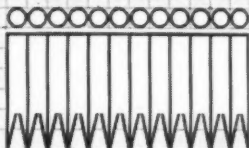


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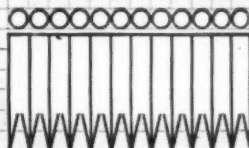
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1. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
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*Cortisone, prednisone and prednisolone.

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Resident Physician

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Hamblen, E.C., in Stieglitz, E.J.: Geriatric Medicine, ed. 2, Philadelphia, W.B. Saunders Company, 1949, chap. 41, p. 672.

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1. Stein, I., Stein, R.O., and Beller, M.L.: *Living Bone in Health and Disease*, Philadelphia, J.B. Lippincott Company, 1955, chap. 9, p. 176. 2. Anderson, H.E.: *J.A.M.A.* 168:173 (Sept. 13) 1958. 3. Goldzieher, M.A.: *Geriatrics* 1:226 (May-June) 1946. 4. Hamblen, E.C., in Stieglitz, E.J.: *Geriatric Medicine*, ed. 2, Philadelphia, W.B. Saunders Company, 1949, chap. 41, pp. 657-673. 5. Kurzrok, L.: (Correspondence), *Mod. Med.* 26:33 (Oct. 1) 1958. 6. Rivin, A.U., and Dimitroff, S.P.: *Circulation* 9:533 (Apr.) 1954. 7. Griffith, G.C.: *Obst. & Gynec.* 7:479 (May) 1956. 8. Stoddard, F.J.: *Obst. & Gynec. Surv.* 10:801 (Dec.) 1955. 9. Shelton, E.K.: *J. Am. Geriatrics Soc.* 2:627 (Oct.) 1954. 10. Randall, C.L., Birch, P.K., and Harkins, J.L.: *Am. J. Obst. & Gynec.* 74:719 (Oct.) 1957.





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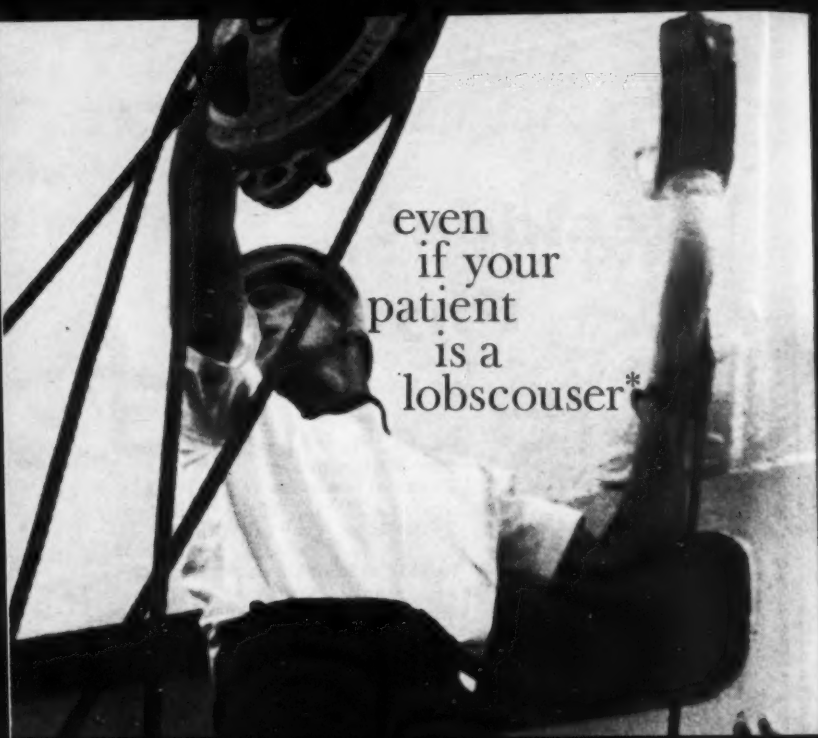
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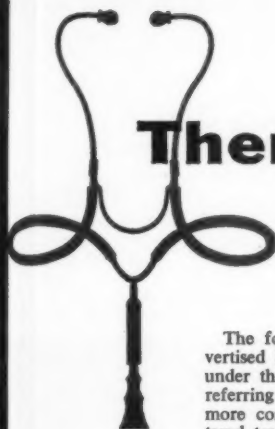
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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

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Garry, M. W.: *Am. J. M. Sc.* 236:330 (Sept.) 1958.

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Colville, J. M.; Gale, H. H.; Cox, F., and Quinn, E. L.: *Antibiotics Annual* 1957-1958, p. 920.

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1. Garry, M. W., *op. cit.* 2. Editorial, *New England J. Med.* 261:152 (July 16) 1959. 3. Nunn, D. B., and Parker, E. F.: *Am. Surgeon* 24:361 (May) 1958.



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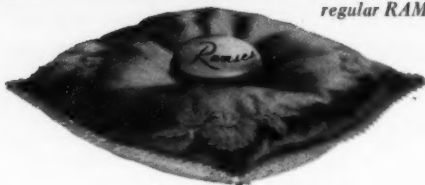
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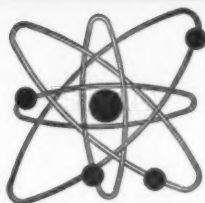
1. Tietze, C.: Proceedings, Third International Conference Planned Parenthood, 1953.

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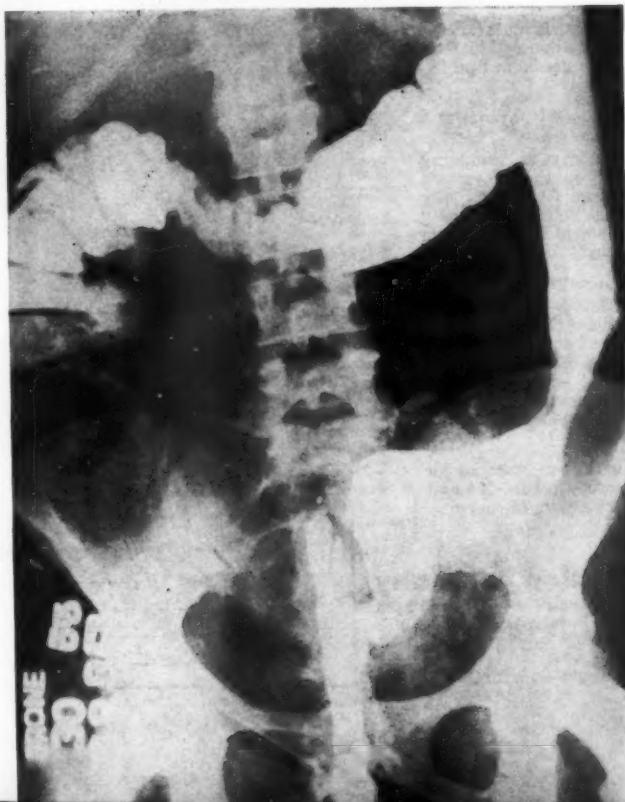


Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
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(Answer on page 194)



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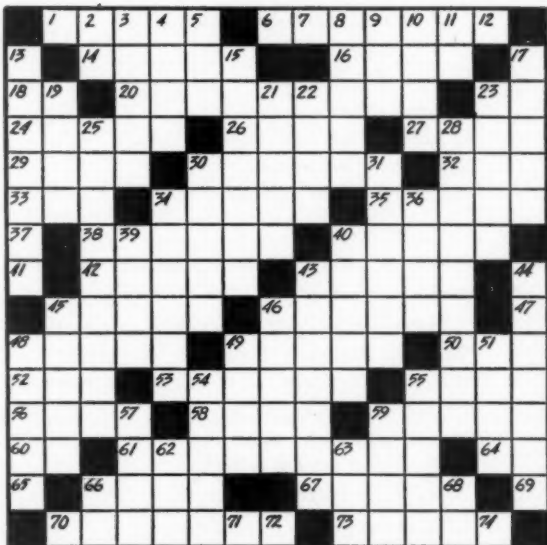
1. Bodily pain
6. Medical practitioners
13. Teaspoon (abbr.)
14. To taste with relish
16. Relating to the rear extremity
17. Liter (abbr.)
18. Radium (abbr.)
20. The origin and development of disease
23. Samarium (abbr.)
24. The incus
26. Birds (Lat.)
27. Roentgen ray
29. Utilizes
30. Foolish (Lat. fem.)
32. Cardinal number
33. Net, Lodestone
34. An injury of the soft tissue by hot liquid
35. One who does not win
37. Absence of (prefix)
38. Hydrocarbon used as a refrigerant
40. Other (Lat.)
41. Sulfur (Symb.)
42. Name given to an artificial fistula for obtaining intestinal juice
43. Constellation
44. Deuterium (abbr.)
45. Suffering (Pl.)
46. To flow out suddenly again, as blood
47. Respiration (abbr.)
48. Take care of the sick
49. The human breast
50. Native of (suffix)
52. Anthropoid primate
53. Shifts of duty
55. Life (Gk.)
56. Increase in temperature
58. Belch (colloq.)
59. Stupors
60. Addition to a structure
61. A paragon's
64. 17th letter of the Hebrew alphabet
65. Sulfur (symb.)
66. Little (suffix)
67. Not dry
69. Dose (abbr.)
70. Knocked down
73. A rectal injection of medicine or food

DOWN

1. 500
2. Bone
3. Stone (Lat.)
4. Egg Shaped
5. Decompose
6. Deuterium (symb.)
7. Oxygen (abbr.)
8. Thorax
9. Sn.
10. Finger nail or toenail

Resident Relaxer

Answer on page 194



11. Reaction or degeneration (abbr.)
12. Without
13. Wounds
15. Krameria root, an astringent
17. Lamina
19. A loop
21. An unimpregnated ovum
22. Castrate
23. Of more sound mind
25. Grow or increase in size (Lat. Subj.)
28. Name given to sign of perigastritis
30. Cicatrices
31. A genus of plants a medicine is made from
34. Black eye (slang)
36. Ear (Gk.)
39. Pronoun
40. City in Greece
43. The natural fat of wool
44. Bandaged
45. The round aperture in the iris
46. Breathes with a loud, hoarse, rasping sound
48. Nostrils
49. Baby born with tetralogy of Fallot
51. Compound of fatty acid with alkaline base
54. Name given to acinous glands situated in the region of circumvallate papillas of the tongue
55. Broad, flat protuberance (Fr. spelling)
57. Within, internal (prefix)
59. The mentum
62. Pertaining to the ear (prefix)
63. —lom, body cavity of the embryo
66. The (Span.)
68. Temporo-mandibular
70. Make (abbr.)
71. Electron (Symb.)
72. Day
74. Anterior (abbr.)

Letters to the Editor



*Unsigned letters will neither
be published nor read.*

*However, at your request,
your name will be withheld.*

Military Service

The editorial and the article, "Military Service Now—" in *Resident Physician*, July 1959, did not point out one very definite advantage in deferring the service for at least a year.

An M.D. entering the service right out of his internship is usually assigned as a General Medical Officer, which can sometimes involve a pretty dull assignment. An M.D. with a year of specialty training is usually assigned as a Class "D" Specialist. This means he spends virtually all of his time in his area of interest, and at a small hospital he is likely to be chief of his service.

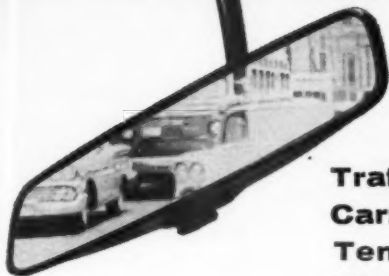
If Board Certified consultants are available—and they usually are—the Class "D" Specialist can frequently get a year of preceptor or practice credit toward Boards.

In occasional instances, a year of actual residency credit may be given.

My advice to students and interns facing the service problem now would be:

1. Get as much specialty training as possible before entering the service.
2. Apply for a Class "D" or higher specialty rating if you think you have any chance of getting it. (Less than a year's training will qualify in some instances.)
3. Keep careful records of all operations performed and training received plus a Medical Officers Training Record.
4. Correspond with your respective American Specialty Board regarding the possibilities for credit.

—Continued on page 38



Traffic: jammed
Car: stalled
Temper: mild
Ulcer: quiet

Here's a man whose ulcer once would have protested strongly—not just at traffic problems—but at the entire gamut of stress to which modern man is subjected.

His physician, aware that *the patient as well as the ulcer* must be treated, has prescribed ALUDROX SA.

eases tension • promotes healing
relieves pain • reduces acid secretion
inhibits gastric motility

ALUDROX[®] SA

Suspension and Tablets: Aluminum Hydroxide Gel with Magnesium Hydroxide, Ambutonium Bromide and Butabarbital, Wyeth



Philadelphia 1, Pa.

—Continued from page 30

If you can't get a specialty rating, check into flight surgery or other special training programs which are available. Some of them are extremely worthwhile.

David W. Furnas, M.D.
San Francisco 22, California

ECFMG, Welcome!

I have had the good fortune of receiving your journal since it was first printed. May I say that you are rendering a real service to all residents and interns. Indeed your journal fills a real need for us in training and it is always amazing to me to see how wonderfully your Mediquiz can stimulate our thinking.

The reason I am writing to you is in reference to the recent article concerning the ECFMG examination which appeared in one of the past issues of the journal. I am a foreign physician and have passed this exam since it was instituted. I am also from one of the so-called nonapproved (but not disapproved) foreign medical schools.

In the article I am referring to, fear is expressed that this exam may keep away from this country many physicians and seems to imply that the exam will be made easier or suppressed.

The ECFMG examination fills a tremendous need because for the first time since the war, it will permit the elimination of the unjust and hypocritical list of so-called "approved" schools. The statement contained in the AMA journal that states many non-approved schools are so because they have not been visited by American observers has always been a very sad sound in my ears; in fact, when you consider it, a hundred thousand Americans go to Europe every year, and yet the Italian, French and German medical schools are not on the approved list. One draws the conclusion that the members of this approving body must be the least travelled people in this country.

When a paradox exists which puts the worst student, let's say, of a Swiss school ahead of the most brilliant French or Italian student, then one can understand why the sense of justice of any honest individual cannot be but hurt.

For too many years this unjust and inhuman treatment has been going on and the ECFMG should, therefore, be more than welcome by any sound minded individual.

The ECFMG should be main-

—Continued on page 46

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page 46

Physician



—Continued from Page 38

tained and the exam should continue to be what it is, if it is to serve in separating the men from the boys. I hope the cry of some hospitals which cannot get enough interns does not spoil all the good the Council is doing.

The Council is needed and should continue its very important functions to stop forever the injustices perpetrated against many good foreign medical schools.

R. T. Fesares, M.D.
Columbus, Ohio

AMQ Exam

The undersigned went to considerable pains and expense to go to a foreign medical school that was on the A.M.A. Council on Education approved list. It would seem both punitive and illogical that graduates of such approved schools should now be made to lose their status retroactively by the introduction of the A.M.Q. Examination two years ago.

We are now expected to pay \$35 for evaluation and validation of these same credentials that were valid until two years ago, then another \$15 to take the new examination. This combination brings us back to the same position of approval vis-a-vis the

various state boards we enjoyed up until two years ago.

What next? This new organization established a precedent of uncertainty for all foreign graduates as to their future. Who knows what will be the next requirement that supersedes all others, and for how many years after medical school will we still be able to hurdle each new examination?

Kenneth M. Clark, M.D.
Odette M. Clark, M.D.
Univ. of Wisconsin
University Hospital
Madison, Wisconsin

*ECFMG'S Executive Director,
Dr. Dean F. Smiley, replies:*

May I point out that though the E.C.F.M.G. was organized and opened its doors in October 1957, it is not until January 1 of 1960 that our sponsoring agencies are withdrawing the list of 50 foreign medical schools whose graduates they have previously recommended be considered on the same basis as graduates of U.S. medical schools. There is a retroactive element in this situation, but it has been softened as much as possible by this long waiting period.

I should point out, also, that it is not until July 1, 1960 that

—Concluded on page 54

**it's as easy as 1, 2, 3 to use*

HYDRODIURILTM

(HYDROCHLOROTHIAZIDE)

Initiate therapy with HYDRODIURIL: one 25 mg. tablet or one 50 mg. tablet once or twice a day. HYDRODIURIL by itself often causes an adequate drop in blood pressure over a period of two to three weeks. This may be all the therapy some patients require.

Add or adjust other agents as required: HYDRODIURIL enhances the activity of all commonly-used antihypertensive agents; thus, the dosage of other medication (rauwolfia, reserpine, hydralazine, veratrum) should be initiated or adjusted as indicated by patient condition. If a ganglion-blocking agent is contemplated or being used, usual dosage must be reduced by 50 per cent.

Adjust dosage of all medication: the patient must be frequently observed and careful adjustment of all agents should be made to establish optimal maintenance dosage.

Supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000.

Additional literature for the physician is available on request.

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MERCK SHARP & DOHME, Division of Merck & Co., INC., Philadelphia 1, Pa.

—Concluded from page 46

our four sponsoring agencies expect all cooperating hospitals to see that they no longer have any foreign medical graduates on their internship or residency lists, who have not been Certified either by the E.C.F.M.G. or by licensing by the State Board of Medical Examiners of the state in which their hospital is located. In inaugurating this new E.C.F.M.G. Certification plan, the effort has been to put it in smoothly and slowly and to avoid undue hardship and confusion. After you have taken the examination, I think you will come to the conclusion that it is very carefully planned and skillfully put together. Each question has been used on several hundred U. S. graduates and we have the outcome of its use before us, as this examination is made up. Six different medical teachers, each from a different field have to agree that there is only one best answer or the question is abandoned. Every question is gone over by a Professor of English to put it into simple basic language, presumably well un-

derstood by candidates whose early training was in another language. Graduates of some of the 535 foreign schools are passing this examination in terms of seven out of eight. Graduates from other less favored schools at the other extreme, will only pass our Examination in terms of one out of nine. Nevertheless, we are finding and very pleased that we are finding, that what is considered to be good medical teaching in the United States is considered to be good medical teaching in most of the countries of the world.

After you take our Examination, I will be very much interested to see if you are not convinced that we have a very well planned Examination, which is meeting a very important need in enabling medical graduates of 553 medical schools around the world to qualify themselves for internship and residency positions in U. S. hospitals.

Dean F. Smiley, M.D.
Executive Director
E.C.F.M.G.

Perrin H. Long, M.D.



Editor's Page

The Genesis and Ecology of Clinical Investigation

II. The Ecology

In the September issue of *RESIDENT PHYSICIAN* the genesis of the clinical investigator was discussed. Certain of the characteristics of clinical investigators were defined and the belief was expressed that they were born and not made. At this time we wish to discuss the ecology of clinical investigation, i.e., what creates a favorable environment for such investigation and where does one find these environments in the United States.

To begin with, the initial assumption will be made that while the clinical investigator has a distinct and characteristic personality, he will not fare well unless he is *trained*. The purpose of training in clinical investigation is twofold. First, to teach techniques which will be needed by the investigator and to discipline his mind in research thinking. Secondly, during their training period, the sheep can be separated from the goats. The opportunity is afforded to determine, with a considerable degree of accuracy, which individuals have the type of personality and make-up which will permit them to become productive clinical investigators.

Now, what are the characteristics of a good training and educational environment? Well, first of all one can say, "a truly collegiate and university atmosphere," i.e., where a group of scholars and pupils are gathered for the purpose of study (of disease or health) and instruction (of medical students and younger physicians). Such an environment provides the enormous stimulation derived from teaching at undergraduate and graduate medical levels. In the most suitable of such environments, teaching duties should not occupy more than one-third of the clinical investigator's time. He must have time to think and to work on the problems of his own selection. The college, university, and hospital must have adequate, properly equipped, and abundantly supplied research laboratories. In both the college and the hospital, administration should be seen, but not felt or heard, which means that the clinical investigator is not bound down by the details of university or hospital administration. Adequate technical assistance must be provided the clinical investigator, *once he has passed his period of fellowship and early training.*

Initially the trainee in the field of clinical investigation should learn to do all technical or other procedures (such as taking care of his own glassware and instruments) in his field of interest. It's the only way that he can learn to understand what is going on and how technical errors may be avoided or discovered in the future. Not until he has learned his way around his field should the young clinical investigator be furnished technical assistance.

Having just read the description of the environment which is necessary for the development of the clinical investigator, the reader may ask, "Well, where does one find such environments?" Let us look at one possible method for determining where these environments exist. Each year, during the first weekend in May and on the following Monday, Tuesday, and Wednesday, the Federa-

tion For Clinical Research, the American Society For Clinical Investigation, and the Association Of American Physicians meet in Atlantic City to discuss, and listen to discussions of the latest doings in the field of clinical investigation. It was estimated that between three and four thousand clinical investigators attended these meetings in May 1959. About seven hundred scientific articles were submitted for the programs at these meetings.

Now, let us see where these papers came from. By geographical areas one finds the following:

	SOUTH			MID-	FAR
	EAST	EAST	SOUTH	WEST	WEST
Federation for Clinical Research	59%	7%	9%	10%	9%
Society for Clinical Investigation	59%	7%	7%	15%	12%
Association of Physicians	6%	2%	3%	20%	15%

Of course, in evaluating this table, the geographical concentration of medical schools, the membership of the three organizations, and possibly (but one can't be too sure of this in the days of *"Have Grant Will Travel"*) the expense of going to meetings at a distance, must be taken into consideration. However, it is interesting to note that for the Federation program, only *three-quarters* of the medical schools of this country submitted papers. *One-quarter were not represented!*

Now having considered these figures, let us see which cities were heavy contributors of papers:

	BETHESDA				
	BOSTON	N.Y. (N.I.H.)	PHILA.	BALTI.	
Federation for Clinical Research	33	30	12	10	8
Society for Clinical Investigation	40	25	10	4	8
Association of Physicians	8	10	1	1	3

At this point one further step may be taken. If the origin of the 33 papers submitted from Boston for the Federation program is checked, 23 are found to come from hospitals associated with the Harvard Medical School. A further breakdown shows that 18 of these 23 contributions came from the Second and Fourth Medical Services and the Thorndike Memorial Laboratory of the Boston City Hospital, and Peter Bent Brigham Hospital. To your Editor, this is very interesting.

In conclusion, one can say that while environments which are excellent for clinical investigation exist all over the United States, the heavy concentration of such environments appears to be on the Middle Atlantic and the Northeastern coastal areas of this country.

TRUDEAU FELLOWSHIPS

The American Trudeau Society is accepting applications for fellowships in the field of respiratory diseases and tuberculosis to assist in the training of investigators and teachers of medicine. For detailed information, write the Society at 1790 Broadway, New York 19, New York.

10 Ways to Build Your Practice Faster

Terry S. Vincent, M.D.

Insecurity and lack of confidence plague many house staffers as they get ready to leave the familiar hospital environment for the challenge of private practice.

- *How long will it take you to develop a practice with sufficient income to sustain you?*

- *Will you be able to handle your first patients successfully?*

- *Will your patients come to you immediately or will you have to survive through a long waiting period?*

- *When will you be able to pay for your equipment just purchased?*

- *Will your uncertainty be detected by the patient?*

Sure, these are important questions. But you needn't be overwhelmed with doubt. You've had

Here are some tips for getting and keeping patients in your first months of private practice.

excellent training. Your future is before you. And you can pretty much make your professional career what you will.

Just as old wives' tales have chilled the hearts of many a June bride, stories of private practice woe told graduating residents by physicians (who grimly relate the "terrible ordeal" they endured) do little to build confidence. Yet, most of these stories are gross exaggerations.

Actually, there's a lot you can do to hasten the arrival of a suffi-

cient number of patients to put your practice on a paying basis in the early months.

So let's set the scene. You're ready to open your office. You face the bleak prospect of high expenses eating up your gross income. What can you do ethically to curtail the waiting period, to speed up the flow of patients?

Announcements

Announcement cards are appropriate and ethical. In general, announcement cards may be mailed when you:

- First start to practice.
- Return from military service or other prolonged absence.
- Move your office location.
- Enter a partnership or group.
- Enter a specialty.
- Have a partner or associate join you.

To whom may you ethically send announcements?

As a solo practitioner you will be well within ethical bounds if you send them only to other doctors in the community, the drug-stores in your neighborhood and the supply houses.

A temptation certainly exists to send an announcement to all business establishments within your trade area. This is frowned upon as unethical by the board

of censors of your local medical society.

If you have any doubts on this score, call them. Give them your list. Abide by their decision.

If you are entering a partnership or joining a group, you can ethically send announcements to the doctors, the druggists, the medical supply companies, and *with the consent of your partner or group*, to patients in the already existing practice.

Usually, however, the established doctor will announce that an associate is joining him, not vice versa.

The announcement contains the bare essentials and is worded in the accepted professional form. For example:

DANIEL P. SMITH, M.D.
ANNOUNCES THE OPENING
OF OFFICES AT
7723 HIGHLAND BOULEVARD
IN THE PRACTICE
OF GENERAL SURGERY

The telephone number and office hours may sometimes be added. That's all. No autobiography. No claims. No advertisement of any kind.

Business cards

Another ethical medium in the carefully restricted practice of advertising the fact that you are a doctor is the standard *business*

card. These, as with the announcements, must be in the accepted professional taste in both appearance and wording. Simplicity is the keynote. Your name, address, telephone number, specialty, and perhaps your office hours. Small type, black on white, and no claims as to ability, training, economy or service.

There is another point to remember. The use of cards can be overdone if you make it obvious that you need the business by thrusting a card into the hand of every person you meet. This then becomes advertising and is unethical.

However, if during a social evening someone asks you the nature of your practice or its location, you may offer a card. And too, a little container of cards on your receptionist's desk is in keeping with the ethics of your position.

Drug stores

Druggists can be helpful to you in building your practice. Most doctors have a few favorite pharmacists, buy supplies from them, and ask them to stock special medications that they may prescribe. But favoritism, of course, is not extended to the point of urging patients

to take an Rx to a particular pharmacy. As there exists a free choice of physicians, so should there exist a free choice of druggists.

Often the pharmacist will offer to supply you with free prescription blanks. Some physicians will not accept these. But ethically speaking, there is nothing improper unless the blanks carry some suggestion or direction such as "take this to Meyer's Pharmacy."

Prescription blanks should simply state the name of the pharmacy, address, and the telephone number. You can rotate prescription blanks to avoid favoritism.

Druggists can be a source of referrals. How important this will be to your practice, of course, depends upon your specialty, the area and customs. Generally, people ask their neighbors before they ask the druggist. But this is not inevitably the case. Older patients may ask their pharmacist "who'd be a good man to see about this lumbago?" Such referrals from pharmacists however, must be the result of a friendly relationship between you and the pharmacist and not the product of a business agreement or conscious goal.

No physician was ever hurt

by scrupulous adherence to ethics

Available

Availability is your strong point. Don't sacrifice it by getting lost for hours. Either your telephone answering service, office aide or wife—whoever takes your calls—should be able to reach you within minutes, anytime, day or night.

Get in the habit of calling in for messages and checking before you leave and as soon as you arrive whenever you must be on the road or away from a phone for even 15 minutes.

Local purchase

Naturally any rapport you can establish with the tradesmen in your community will be reflected to your advantage. In this respect it is important that you identify yourself with a part of a neighborhood; *always shop locally*.

Office supplies, car servicing, groceries, dry cleaning, and all the myriad things required in your practice and in your daily life, should be purchased in the area where you practice. It's possible that the cost will be greater in certain instances than if you had shopped somewhere else. But the returns in good

will and subsequent referrals will more than offset the small additional expense.

Here again is a case of a natural, friendly relationship producing a happy by-product. It must be spontaneous. Don't consciously attempt to court referrals. This will bring an almost certain loss in community respect.

Health talks

The public appetite for health education is practically insatiable. Most physicians, while not trained public speakers, can talk informally on medical topics, and without talking down to an audience, can approach things medical in easy to understand terms.

Occasionally through a community group or association you may be asked to speak on a certain medical subject of current or general interest. Permit the chairman to introduce you by name and title only. Insist on this. No embellishments. Often it would be wise to clear your talk through the local medical society board of censors.

Be sure you understand your subject thoroughly. Don't attempt to be a humorist. Exercise good taste. Avoid controversy unless you are able to present both sides of the situation with intelligence.

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Courtesy calls

Although many physicians may consider *courtesy calls* on established physicians somewhat passé, there is no question that they do help a new man get off on the right foot. Be certain to make it a professional and not a personal visit. Make it at his office, not his home. And be certain that the established doctor's convenience is considered. Don't just drop in. Call first or drop a courteous note. If you are in a position to invite him to lunch, then he will be in a position to tell his patients and friends just what sort of a character you are.

Professional meetings

Hospital staff and medical society meetings help the young physician stay in the main stream of medicine. They can also be a direct aid in building your practice since you will probably have plenty of time to attend such meetings. Your participation will allow you to make contacts with established men. These contacts can lead to night calls perhaps later to weekend coverage and vacation substitution. You may, of course, choose to remain completely aloof from such activity. But then you will be considered an "outsider." And no doctor

can be truly successful without being known by his brother practitioners. The sooner you get known the better from the standpoint of building your practice. Go slow on accepting an office in the medical society, however, since this could well absorb much of your time and attention to the neglect of your new practice.

One place you should spend time is in the hospital coffeeshop. Here you will get to know your colleagues and they will help you when they are able to.

Professional employment

Definite opportunities to enlarge your practice exist through *affiliation* with an agency which serves large numbers of people in a medical sense. Factories, schools, hotels, labor unions, shipyards, police departments, industrial insurance companies and large stores are examples.

The dignified and professional approach directly to the powers that be or to an appropriate intermediary may lead to a permanent affiliation of this kind. The economic and professional advantages to the young doctor are obvious in such an association. The point is, it won't fall in your lap. You'll have to make some effort however discreet, to feel out this field in your community.

Examining applicants for life insurance deserves special mention. It is one of the handiest practice building aids a doctor can undertake. Simply seek out the manager of an insurance company, or medical director if it is large enough, and state your case: You're new, you can give reliable and prompt service, you are requesting an application for a position as an insurance examiner.

As an examiner you will act only as a fact-finder. You won't diagnose or treat. Although most specialty groups permit their members to engage in this activity, be sure you exercise the utmost caution to avoid stepping on the toes of an established practitioner. This is especially true if this practitioner is in your immediate area or your practice is in a small town.

It has often been said that when an examiner probes a man's past history as well as his inguinal rings, he frequently starts the bond of a doctor-patient relationship that will last a lifetime.

Lay groups

As a last aid in building your practice consider membership in *lay organizations*. Generally, this is overrated as a means of developing a practice. Few members

are willing to confide in a member doctor, perhaps because they fear the personal intimacies might be divulged at the next club dance. Also, too many of the brothers expect special treatment or reduced fees or preferential appointments simply because they know the same secret password as you do.

However, in lay organizations are people. And by meeting people you will more quickly build a successful practice. In this same regard there are two kinds of civic activities, political and nonpolitical. Remember that the sick person wants a competent, dependable physician and doesn't give a hoot whether you vote Republican or Democratic. Leave politics to the politicians—at least until you've established your success, and incidentally, accumulated the wisdom which comes with years.

The nonpolitical type of civic activity is a different matter. Such things as the community chest, county recreation board, Boy Scouts, and other social agencies may lead to some ethical publicity and to quite a number of desirable contacts.

Although *articles* written for lay consumption and mailing *reprints* of papers that appeared in medical journals to other physi-

icians are old practice building devices available to the young specialist, it would be impractical to suggest that your past clinical papers are in such volume as to justify a reprint mailing program.

Remember, *you cannot mail reprints to laymen*. This is clearly a violation of ethics.

And finally, in all these tools for practice building, unless you engage in these activities with something more than building your practice in mind, you'll probably get a pretty poor return for your investment of time and trouble. Obviously you must have a genuine desire to serve humanity as a physician. And just as obviously this must be uppermost in your mind. Your personal financial welfare, while not secondary in terms of your existence, is secondary in terms of your medical practice. Re-

member, too, that people are fairly expert at sensing back slapping for what it is. When a doctor regards his contacts and "friendships" with colleagues, druggists, and lay persons as stepping stones to riches, he is fooling no one but himself.

Above all else, as doubts assail you, remember:

If you are devoted to your work, willing to make reasonable sacrifices to attain a higher degree of perfection, you cannot fail as a doctor. If to you no patient is inconsequential, if thoroughness is your watchword, if you attend scientific meetings, take postgraduate courses, read the best scientific literature available, you can't miss.

Your practice will build. And if you've chosen your location with care, you'll soon be looking for an associate to help you with your growing practice.



CAREERS IN MEDICINE



THE U.S. PUBLIC HEALTH SERVICE

Leroy E. Burney, M.D.

Surgeon General, Public Health Service
U. S. Department of Health, Education, and Welfare

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October

As the principal Government agency concerned with the health of U.S. citizens, the Public Health Service employs more than 25,000, supports a Commissioned Corps of physicians which has served this nation since 1873, and operates nearly 100 general and specialty hospitals through its Indian health, prison and hospital divisions.

It is man's deepest and fullest satisfaction to have a part in serving the cause of humanity. Even as in the day of Hippocrates, physicians today take and believe in the pledge which binds them to "lend their lives and practice their art with uprightness and honor . . ." Thus the men and women of the medical profession who live by that creed have the deep satisfaction of serving mankind. No members of the medical profession can feel a greater sense of satisfaction than the physicians of the United States Public Health Service, active participants in world wide efforts to improve human health and to make life better and longer for all people.

Since 1798, when President

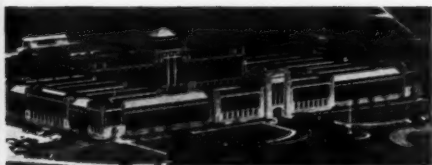
John Adams signed the act creating the Marine Hospital Service, forerunner of today's Public

Health Service, the record of our physicians has been one of accomplishment toward the betterment of human health—historical achievements in the discovery of the causes of disease and milestones in prevention and treatment. Today the accomplishments of Public Health

Service physicians continue to grow, with achievement recognized not only in the United States but throughout the world, where cooperation with the World Health Organization and the International Cooperation Administration is paying steady dividends in improved health in all countries.



LEROY E. BURNEY



USPHS Hospitals, Lexington, Kentucky and (below) the National Leprosarium, Carville, Louisiana.



Agency of health

The Public Health Service is the oldest and largest of the five operating agencies comprising the U. S. Department of Health, Education, and Welfare. It is also the principal agency of the Federal Government concerned with the health of the people of the United States and is one of the world's foremost national health organizations. The Service employs over 25,000 Commissioned and Civil Service personnel in nearly 300 occupational specialties. Many of the Service's programs are directed by officers of

the Public Health Service Commissioned Corps. Most of the physicians in the Service are medical officers in the Commissioned Corps, a career health organization that has served with distinction since its establishment in 1873.

Through the Commissioned Corps, the Service offers the young medical officer opportunities for professional development and experience in many areas of medicine—such as patient care, clinical research, laboratory research, epidemiology, preventive medicine and public health, quarantine duty, and such local-State-Federal community-oriented preventive programs as rheumatic fever prevention, VD and TB control, cancer detection, protection against the hazards of ionizing radiation, and many others.

Indeed, because of the opportunities to practice, to teach, and to do research, the opportunities for professional growth and personal satisfaction in the manifold areas of the Service's responsibilities are unique and unparalleled.

Public Health Service medical officers serve primarily in three major areas of program activity: medical and hospital care, medical research, and preventive medicine and public health.

Through its Division of Hos-

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pitals, the Service operates 16 general and specialty hospitals, with bed capacities ranging from 125 to 1264. Located usually at major shipping points, these hospitals are generally convenient to residential neighborhoods, public transportation and shopping areas, schools, churches, theaters, and cultural, athletic and recreation centers. Within each hospital, Board certified or Board qualified chiefs and deputy chiefs of service are available at all times to provide consultation, guidance and instruction to their staffs.

Patients

The majority of patients are American merchant seamen, officers and enlisted men of the U. S. Coast Guard and their dependents, Federal employees injured at work, officers and crew members of the Coast and Geodetic Survey, and Public Health Service commissioned officers and their dependents. Active duty officers and enlisted personnel of the Army, Navy and Air Force, and their eligible dependents, are also admitted.

Twelve of the hospitals provide general medical and dental services, with organized departments in the various specialties. These hospitals, each listed with

the number of beds set up for patient care, as of April 1959, are in the following cities:

Boston	244
New York City (Staten Island)	798
Baltimore	366
Norfolk	248
Savannah	125
New Orleans	400
Memphis	134
Chicago	160
Detroit	202
Galveston	163
San Francisco	453
Seattle	323

Two neuropsychiatric hospitals with special facilities for treating narcotic addiction are maintained at:

Lexington, Kentucky	1264 beds
Fort Worth, Texas	1043 beds

A tuberculosis hospital in Brooklyn, adjacent to the Atlantic Ocean (at Manhattan Beach), has 280 beds. The Service's hospital at Carville, La., with accommodations for 351 patients, is the national leprosarium.

Outpatient clinics are operated by the Division of Hospitals in 22 cities within the continental United States. There is also one in Honolulu, Hawaii, and one in San Juan, Puerto Rico. These are fulltime facilities providing medical, dental and allied services in cities where there are significant



USPHS Hospitals. Staten Island, N. Y.
and (below) Seattle, Wash.



concentrations of beneficiaries eligible for medical care but where no Service hospitals are located. By special arrangements, staff members of some of the clinics may treat their emergency cases in community hospitals.

Training activities in the 16 general and specialty hospitals cover a wide range of hospital and clinic functions. In addition

to formal teaching programs, there are staff meetings, clinical conferences, lectures, and demonstrations, scheduled regularly to keep all staff members up to date with respect to the most recent medical developments.

Research

Research activities in the PHS hospitals naturally correspond to the supply and variety of clinical material. The abundance and great variety of pathological entities seen in patients admitted by our hospitals and clinics permit both clinical and basic research in diseases of the cardiovascular, gastrointestinal, renal, endocrine, nervous, and neuromuscular systems, and diseases of metabolism, advanced age and the integument. Patients from abroad also contribute to this rich resource for study and research.

The Service's hospitals maintain excellent relations with local medical colleges and professional organizations. Faculty members participate regularly in the patient care, teaching and research programs of the hospitals. In turn, many medical officers from our hospitals serve actively as faculty members of local medical schools. In several of our hospitals, two-way cooperation with local medical faculties in both

research and professional training has long been traditional.

House staff programs

There are 88 AMA-approved medical internships at the Service's hospitals in Baltimore, Boston, New Orleans, Norfolk, San Francisco, Seattle and Staten Island. Formal residency training programs, fully accredited by the AMA Council on Medical Education and Hospitals, are offered at the PHS hospitals in Boston, Staten Island, Lexington, Baltimore, Norfolk, New Orleans, San Francisco, Seattle and Detroit. This training is given in the following specialties: General surgery, internal medicine, urology, anesthesiology, obstetrics-gynecology, ophthalmology, pathology, radiology, psychiatry, orthopedic surgery, and dermatology and syphilology.

In view of its popularity at the Detroit and Norfolk hospitals, where it continues to be offered, the residency program in general practice was recently started at the Galveston hospital.

Through its Division of Indian Health, the Public Health Service operates 49 general medical and surgical hospitals and four tuberculosis hospitals for American Indians and Alaska Natives (Indians, Aleuts and Eskimos).

Most of these facilities are small, ranging in capacity from 25 to 50 beds. Several are large, providing a full range of specialist services. The largest, at Anchorage, Alaska, has 400 beds.

The Division of Indian Health also operates field health facilities at several hundred other locations to provide preventive services and ambulatory patient care.

Opportunity

The health program for Indians and Alaska Natives provides excellent opportunities for physicians interested in either general practice or early experience in medical practice prior to advanced training. The program uniquely combines both clinical practice and preventive medicine in day-to-day application.

There is an abundance of obstetrical, gynecological and pediatric cases, and a wealth of traumatic surgery cases, in all the PHS hospitals for Indians and Alaska Natives.

Major surgery is performed routinely at all the larger hospitals and, to a limited extent, with the aid of consultants, in the smaller hospitals. The ambulatory medical care load in all the general hospitals is heavy and professionally stimulating.

Illnesses, in addition to the



USPHS Hospital, Rapid City, S. D.

usual, extend to diseases rarely seen in civilian hospitals. They include trachoma, various parasitic diseases, and diseases of the bones and joints. Medical officers usually have a wide latitude of responsibility in the Indian hospitals and are supported by consultants as needed.

Assignments to Indian health centers provide physicians with excellent opportunities for obtaining experience in preventive medicine and public health, as well as medical care for large numbers of outpatients.

Quarters are available at all hospitals located in isolated areas and at most hospitals in cities and towns. New quarters are being added as needed. Information on schools, churches, markets, recreation, social activities, and other matters of importance to the family is available for individual hospitals, upon request from the Division of Indian Health.

The PHS Indian and Alaska

Native facilities are in areas that extend beyond the Arctic Circle, across the Great Plains and deserts, and into the mountains of the West. Generally, these facilities are in smaller communities, and many of them are on Indian reservations. Some occupy sites of old frontier posts, steeped in tradition and colorful history.

Prison medical service

The Public Health Service provides medical, surgical, psychiatric, and dental services for over 20,000 prisoners in 30 Federal institutions, located in 21 states. The medical services in these institutions are very active. The conditions of imprisonment, moreover, provide excellent opportunities for long-term patient care and observation. All of the hospitals located in the larger institutions, and many of those located in the smaller institutions, are fully accredited by the AMA Joint Commission on Accreditation of Hospitals.

The institutions of the Bureau of Prisons provide a wealth of clinical material for opportunities in the practice of general medicine, surgery, psychiatry, and other specialties, and make full use of over 200 consultant specialists in all branches of medicine.

Some of the Public Health



Dr. Steven Spencer, PHS physician, takes blood pressure of Navajo patient at PHS Indian Hospital, Ft. Defiance, Ariz.

Service's major achievements in medicine in recent years have been made possible through work done with prisoner-volunteers, an opportunity rarely available to the research-minded physician.

For example, Dr. Robert Coatsney used prisoner-volunteers at the Federal Penitentiary in Atlanta, Ga., and the Federal Correctional Institution at Seagoville, Texas, in evaluating chloroquine, the antimalarial drug of choice

in many parts of the world.

Dr. Robert Huebner was able to develop the adenovirus vaccine for upper respiratory infections through studies with prisoner-volunteers at the Federal Reformatory in Chillicothe, Ohio. And Dr. Wayland Hayes, Jr. has conducted significant toxicity studies of insecticides at the Federal Correctional Institution at Tallahassee, Fla., and the Federal Penitentiary in Atlanta.

NEXT MONTH: *PHS in Foreign Service and Preventive Medicine.*

THIS MONTH'S HOSPITAL

is unique in many respects. It is not a vast medical center. It is not a university hospital. Yet, as with hundreds of community hospitals throughout the United States, it maintains a teaching program for residents and interns. Its uniqueness lies in the fact that three years ago it deliberately set out to overcome many of the traditional disadvantages of the small teaching hospital. From among its senior attendings, a "clinical faculty" was appointed, with selection based not on seniority but proficiency and enthusiasm for teaching, plus willingness to utilize their private patients for teaching. Affiliation with the Regional Hospital Plan of New York, a program designed to raise the level of teaching in community hospitals, resulted in an extensive program of clinics and lectures by visiting professors from major medical schools and medical centers in the area.

Norwalk Hospital's new and expanded educational program shows how one community hospital of 300 beds improved the teaching program for its residents and interns.

NORWALK HOSPITAL

Founded as a six-bed dispensary in a rented house in 1893, the Norwalk Hospital has been located in three different sections of Norwalk, Connecticut, in its 65-year history. Six years after it was established, the first hospital building—a 26-bed unit containing one operating room—was constructed. The present site was purchased in 1914, and since 1918, there have been three wings added to keep abreast of the population boom in the hospital's service area.

Today, Norwalk Hospital has a capacity of 305 beds and 40 bassinets, and its services embrace all major specialties.

In 1956, the Medical Education Committee of the Norwalk Hospital adopted a new program based on the premise that "proficiency in teaching is a special skill, not necessarily related to staff position."

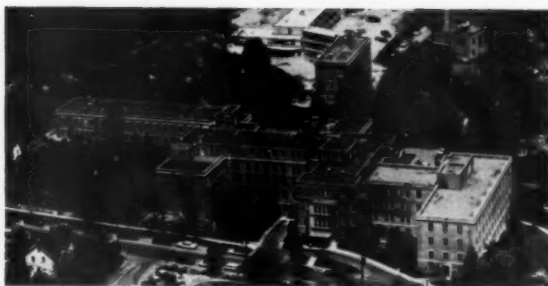
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The 340-bed Norwalk Hospital at Norwalk, Connecticut.

In developing this program for house staff education at the Norwalk Hospital, one of the first questions the committee studied was this: Why do community hospitals have such difficulty in filling their quota of interns through the Matching Plan, while university hospitals readily meet their constantly increasing requirements?

Outstanding

Listing the "advantages to interning in a community hospital," Norwalk's Medical Education Committee concluded that young physicians "can acquire life-long ties, a place to practice, a niche in the area where they will settle, and a familiarity with the type of practice in which they will later engage."

Further, the committee felt that as generalists and specialists

have joined the migration to the suburbs as a place to live and raise their families, attending staffs of community hospitals today often are composed of physicians "as outstanding as those found teaching in medical schools—in fact, often the same men." Nor is there any dearth of "clinical material" in these nonuniversity hospitals, reasoned Norwalk's medical staff.

"Yet, with all the advantages of a place to practice, excellent attendings and abundant patients, the prospective intern still gives first thought to the university hospital for his internship."

Teaching

In an effort to reverse this trend, and make at least one community hospital more attractive, the one factor which Norwalk's administration and staff felt

NORWALK HOSPITAL

DIRECTORS OF EDUCATION AND SERVICES

DIVISION

OTHER TEACHING AFFILIATIONS

Allen M. Margold	Medical Education and Urology	
Daniel H. Adler	OB-GYN	Clinical Instructor OB-GYN, Albert Einstein School of Medicine
Roy N. Barnett	Laboratories	Assoc. Clinical Prof. Pathology, Yale University School of Medicine
Harold Genvert	Surgery	Ass't. Prof. Clinical Surgery, Cornell Medical School
David D. Giardina	Radiology	Instructor in Radiology, Yale University School of Medicine
Neil F. Lebharr	Pediatrics	Ass't. Prof. Pediatrics, N.Y.U.-Bellevue Medical Center
Ignatius J. Vetter	Medicine	

could be controlled was the level of clinical teaching.

"Too often," said one senior staff man, "senior attendings achieve their positions solely by seniority and clinical skills, but lack the talent for teaching, which is a corollary of their position."

After study, Norwalk went to work. A "Clinical Faculty" was selected to be responsible for all house staff teaching. Senior members include a Director of Medical Education, and an educational director for each of the six major divisions. All are diplomates of their specialty boards and were qualified by the staff and by the Director of Graduate Medical Education, Yale University School of Medicine,

who served as a consultant.

The entire staff of more than 200 physicians was polled and from those indicating strong interest in teaching house staff members, the "Clinical Faculty" selected the best qualified by reason of knowledge, teaching ability and willingness to utilize their private patients for teaching.

The completed "faculty" consisted of a "dean," six "professors," and "instructors." New "instructors" are added as the "professors" recommend.

Further strengthening of the Clinical Faculty plan was then accomplished by affiliation with the Regional Hospital Plan of New York. This program, directed by Dr. Clarence de la Chapelle, un-



Pediatric residents give newly-admitted patient a thorough examination.

der the overall direction of New York University Dean Donal Sheehan, is specifically directed at raising the level of teaching in community hospitals. The resulting program can best be illustrated by a typical week's schedule. (Page 87.)

Lectures

The Medical Consultants have not only added actual medical information, stimulating to both house staff and attending physicians, but have also contributed in the realm of teaching methodology. This has been done both directly to faculty members and through reports to Dr. de la Chapelle, later reviewed with Norwalk's Medical Education

Director. In another aspect of this affiliation, Norwalk Hospital house staff members attend lectures and rounds at New York University - Bellevue Medical Center. Organization and coordination of these back-and-forth visits, as well as the general program, are carried out by the Medical Education Director.

Clinics

Naturally, teaching includes many day-to-day duties not formalized on the published schedule. There is the primary responsibility under supervision for the care of service patients, comprising about 12 percent of all patient days. There is the secondary responsibility for all private pa-

OUTPATIENT CLINICS

Tumor	Every other week
Cardiac	Weekly
Medical	Weekly
Pediatric	Weekly
Surgical	Weekly
Mental Health	Daily
Well-Baby	Every other week
Ob-Gyn	Weekly
Dental	Twice weekly
Dermatology	Monthly
Chest Diseases	Monthly
Neurosurgery	Twice monthly
Orthopedic	Weekly

tients, daily ward rounds with attending physicians, shared responsibility for the 12,000 Emergency Room patients and the 34,000 outpatient visits at 132 clinics. Attendance is also encouraged at the monthly Journal Club and the bi-weekly, audio-visual program.

Programs

The resident and intern programs of the Norwalk Hospital are approved by the Council on Medical Education and Hospitals of the American Medical Association. The one-year rotating internship includes three months in surgery, three months in medicine, two months in obstetrics-gynecology, two months in pedi-

atrics and anesthesia, and two months in the emergency room and x-ray. There is a four-year residency in pathology, and one-year residencies in medicine, surgery and obstetrics.

Hospital

The Norwalk Hospital is located high on a hill overlooking a large area of Fairfield County, Connecticut, and the waters of Long Island Sound. New York City is an hour away and New Haven, home of the Yale Medical School, is half an hour distant.

One of the fastest growing regions in the United States, as evidenced by the construction of 20 new schools during the past 10 years, the Norwalk area population consists of skilled workers and a large segment of New York City commuters. The hospital serves as the medical center for nine surrounding communities, whose citizens contribute considerable moral and financial support to maintain up-to-date facilities. (For example, it is the first hospital in Connecticut to have an artificial kidney.)

Norwalk Hospital employs more than 500 full- and part-time personnel, including a house staff of 13 interns and 10 residents, and 100 graduate nurses.

The medical library contains

NORWALK HOSPITAL

MONDAY

- 11:30 AM Ob-Gyn Chart Conference
- 1:00 PM Pathology Conference
- 4:00 PM Surgical Grand Rounds

TUESDAY

- 10:30 AM Tumor Clinic: Guest Consultant, Dr. John L. Pool, New York Hospital
- 1:00 PM X-ray Conference
- 1:00 PM Surgical Efficiency Committee Meeting
- 4:30 PM Medical Efficiency Committee Meeting
- 5:30 PM EENT Department Meeting
- 7:30 PM Audio-Visual Conference: Differential Diagnosis of Uterine Bleeding

WEDNESDAY

- 1:00 PM EKG Conference

THURSDAY

- 10:30 AM Cardiac Clinic: Guest Consultant, Dr. H. H. Marvin, Yale University School of Medicine
- 11:00 AM Pediatric Meeting: Guest Consultant, Dr. Vincent DePaul Larkin, Associate Clinical Professor of Pediatrics, NYU-Bellevue
- 2:00 PM Orthopedic Rounds and Conference: Dr. Ortho C. Hudson, Associate Professor of Clinical Orthopedic Surgery, NYU-Bellevue
- 2 to 3:30 PM Clinic and Conference on Cardiac Arrest, Operating Room and Postoperative Anesthetic Complications; Demonstration of New Equipment, Dr. Emery A. Rovenstine, Professor of Anesthesiology, NYU-Bellevue
- 3:30 PM Surgical Conference, Dr. David Lyall, Professor of Clinical Surgery NYU-Bellevue

FRIDAY

- 3:00 PM Medical Rounds and Conference on Endocrinology, Dr. Elaine Ralli, Associate Professor of Medicine, NYU-Bellevue
- 4:30 PM Medical Division Meeting and CPC



Residents review films at weekly x-ray conference.

hundreds of current textbooks and subscriptions to more than 75 journals. The hospital conducts an accredited school of nursing with a capacity for 150 student nurses, and an approved school for medical technologists. During the fiscal year ending September 1957, more than 14,000 inpatients were treated for a total of nearly 100,000 patient days.

NORWALK HOSPITAL

Ward Patient Days	11,600
Emergency Room Visits	11,989
Outpatient Visits*	34,440
Total Deliveries	2,127
Surgical Operations	5,187
Laboratory Procedures ...	143,186
Autopsy Rate	50%
Autopsy Number	215
X-Ray Examinations	20,231
X-Ray Treatments	2,594
Cystoscopic Examinations ..	622

* Private and Clinic

Scholarship

Recognizing that for many years to come American hospitals will supplement staff requirements with foreign medical graduates, to attract the best of these physicians, Norwalk Hospital maintains a scholarship program with a number of leading European medical schools. Under an arrangement agreed upon by the schools, several English-speaking scholars are selected each year by the deans of those schools to spend a year of postgraduate work at Norwalk Hospital, learning American concepts of medical service. The scholars are furnished transportation and are given appointments as interns. By this means, an exchange of medical concepts is made possible between interns from American schools and those from foreign schools.

Interns and residents are furnished rooms, meals, uniforms and

NORWALK STIPENDS

Interns	\$160
1st year Residents	195
2nd year Residents	230
3rd year Residents	265
4th year Residents	300

laundry service. Individual rooms are provided for unmarried house staff members.

Attractive furnished apartments for married house staff members are available on the premises or in the immediate vicinity. These are rented complete with utilities for \$40 a month.

A vacation of two weeks is provided, and this may be split into periods of one week each

with approval of the Director of Medical Education.

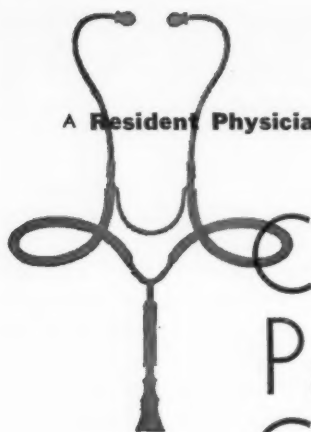
The Personnel Office of the hospital assists the wives of married interns or residents find employment either in the hospital or locally.

Outside meetings

Opportunities for learning reach out beyond the walls of the hospital. The hospital maintains a special fund to enable residents and interns to attend conventions at nearby cities. An opportunity is also provided the house staff to attend meetings and clinics at Yale University, NYU-Bellevue Medical Center, The Academy of Medicine in New York City, and at other medical centers in nearby New York.

Medical information is passed across the table in the staff dining room.





A **Resident Physician** MONTHLY FEATURE

Clinical Pathological Conference

Norwalk Hospital, Norwalk, Connecticut

On 12-18-57 at 4:58 PM this 53-year-old white, married male was transferred from Hospital X to the Medical Service of the Norwalk Hospital with an admission diagnosis of uremia and cerebral vascular disease. The patient's chief complaint on admission was generalized weakness and inability to walk.

Present illness

Approximately 10 months prior to this admission the patient was admitted to the Norwalk Hospital for treatment of a

"carbuncle" on his back. This was excised en masse. The surgical specimen was reported as "ruptured sebaceous cyst with acute and chronic inflammation."

At that time there was a history of known diabetes of approximately 7 years' duration. Following hospital discharge he noted gradual and progressive weakness in his lower extremities until, approximately 4 months ago, he was unable to walk. Because of this he entered the X Hospital on 8-12-57.

At that time he also had some

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For the monthly conferences at the Norwalk Hospital, an abstract is prepared by one of the staff physicians. This is mimeographed and distributed to attending and house staff a week before the meeting. Discussion is opened by an attending physician selected in rotation from a panel of participants. The floor is then open to all staff and house physicians, followed by the presentation of pathology. The appended case was presented June 13, 1958. Presiding was Roy N. Barnett, M.D., Chief Pathologist, and Associate Clinical Professor of Pathology, Yale University School of Medicine.

difficulty in coordination of fine movements of the fingers, as well as some incontinence of urine.

Physical findings

On admission to X Hospital, neurological examination showed hyperactive deep tendon reflexes and a positive Babinski on the left side. A lumbar puncture revealed an elevated spinal fluid protein of 173 mgms. A myelogram followed and was unsatisfactory although a questionable lesion in the region of the 6th and 7th cervical vertebra could not be ruled out. The patient was discharged and returned to the X

Hospital 3 days later for a repeat myelogram: the cervical defect seen in his first examination of the cervical region was now interpreted as osteophytes. On 8-27-57 the patient became febrile, manifested increasing weakness and had hematuria.

Blood cultures done at this time revealed a staphylococcic septicemia for which the patient received Chloromycetin, penicillin and streptomycin with hydrocortisone. The patient showed some clinical improvement on this therapeutic regime; however, an episode of gastrointestinal bleeding, presumably secondary to steroid medication had occurred. Because of this steroids were discontinued.

Following this the blood cultures were negative but there was an exacerbation of his clinical complaints and in addition there was swelling with pain in the left shoulder which became abscessed. The possibility of an osteomyelitis of the head of the humerus could not be ruled out.

The patient also had skin and muscle biopsies at this time and these were interpreted as suggestive of collagen disease.

During his hospital course he developed severe anemia, presumably due to his G.I. bleeding with a possible hemolytic com-

ponent for which he required frequent transfusions. His reticulocyte counts were in the range of 1-3% at this time. In addition, clinically he had symptoms of prostatism with increasing retention of urine for which a suprapubic cystotomy was done followed by the establishment of a drainage tube.

Laboratory

On admission NPN was 28 mgm% and 2 weeks later rose to 72 mgm%. This fell to within normal range in 4 weeks after his admission where it remained for the following 2½ months.

On 12-2-57 his NPN rose to 120 mgm% and remained elevated. The patient was maintained on low dosages of insulin for his diabetes early in his course of treatment, and because his fractional urines were persistently negative, insulin was later discontinued. His serum albumin fell to 1.83 gm but his calcium and inorganic phosphorous were normal.

Liver function test was variable and showed a more or less persistent elevation in his alkaline phosphatase and some BSP retention. Cryoglobulins were negative. A G.I. series was indeterminate and Bence Jones Proteins were not found at any time.

Skull films were indeterminate as were his chest x-rays and IVP's. A bone marrow aspiration showed a slight increase in plasma cells. This was thought to be a compatible finding seen in malignancy or chronic infection. L. E. preparations were negative. Antistreptolysins were 265 units and Coombs tests were negative. Repeated blood culture taken following treatment with penicillin and Chloromycetin were negative.

In spite of vigorous medical treatment and diagnostic studies, there was no specific explanation or diagnosis given to this patient's basic illness while he was hospitalized in the X Hospital, and it was apparent that he was pursuing a relentless "down-hill course."

His discharge diagnosis prior to transfer to the Norwalk Hospital was chronic staphylococcic septicemia which may have precipitated an acute glomerulonephritis, or that he had a chronic glomerulonephritis and/or Kimelstiel-Wilson's disease.

Because of the previous episode of gastrointestinal bleeding following steroid therapy there was great reluctance to re-establish the steroid medications for treatment aimed at his possible existing collagen disease.

The patient was transferred on 12-18-57 to the Norwalk Hospital for "terminal care." At the time of transfer the patient was on the following medications: Compazine 10 mgms%, 3 times a day; erythromycin, 1 gm a day; Chloromycetin, 1 gm a day, Colace and Maalox.

History

Patient had a negative past history except for his diabetes and previous treatment of a carbuncle on the back. Family history was non-contributory. Patient was known to be a heavy cigar smoker.

Final admission

Physical findings on his second and final admission showed that the patient was a well developed, poorly nourished, cooperative, conscious white male constantly hiccupping.

Renal examination revealed no masses either cervical or abdominal. There was no venous congestion of the neck veins.

On examination of the chest the latter was symmetrical, no rales were heard over the pulmonary fields.

Cardiac examination revealed the apex beat to be in the 5th interspace left of midclavicular line. The heart sounds were faint

but regular with absence of murmurs or pericardial friction rub. The abdomen was scaphoid in appearance. There was a cystotomy wound and drainage tube seen in place. No masses or tenderness were palpable. There was no flank bulging indicative of fluid.

The extremities revealed a positive Babinski on the left and there was absence of any hyperreflexia or ankle clonus.

The clinical impression on this admission was 1) uremia, etiology undetermined, and 2) diabetes mellitus.

Vital signs on admission revealed a temperature of 99, pulse rate 70, respirations 18 and a blood pressure of 150/90.

Course

On the morning of the second hospital day after the patient's admission, he was described as lethargic, singultous (hiccupping) still persisted. On this day a chest examination was performed which was reported as normal with calcific densities seen in the lower right axilla, interpreted as either localized to the ribs or pulmonary tissue.

A BUN was reported on the third hospital day as 120 mgms% which represented a diminution in his persistent BUN of 163

which the patient maintained toward the latter part of his X Hospital stay. His lethargy still persisted. A guaiac determination on the fourth hospital day was 4+. This was interpreted as representing a uremic colitis.

On the fifth hospital day the patient revealed a CO_2 of 29 mEq/L, sodium 126, chlorides 81 and potassium of 4.9 mEq/L. Hemoglobin at this time was 10.4 gm, 65%.

He was subsequently placed on Roncovite and his overall physical condition was described as "poor." A urine culture determination reported on the 7th hospital day revealed *E. Coli* which was sensitive to Chloromycetin and terramycin.

The patient showed the following electrolyte determination: CO_2 21 mEq/L, chlorides 56, sodium 107, potassium 4.3. An electrolyte study performed on his urine revealed a sodium of 1.6 gm, 24 hours, potassium 1 gm, chlorides 1.9 gm in 24 hours. On the 11th hospital day there was a sharp drop in his hemoglobin to 5.4 gm. His prior hemoglobin (on the 6th hospital day) was 10.4 grams.

While blood therapy and cortisone therapy was started.

By the 22nd hospital day there was some improvement in the pa-

tient's condition. For the first time he appeared fully alert and coherent, although at this time rales were present in the right lung field. It was the clinical impression that the patient might have a hypostatic pneumonia without evidence of fever. Blood pressure at this time was 120/90. The abdomen was soft and the liver was not palpable, although a 2+ pretibial pitting subcutaneous edema was present. His hemoglobin was now 6.5 gm, RBC 1.057 million. Urinalysis showed 2+ albuminuria. BUN was 44, creatinine 4 and his fasting blood sugar was 122.

On the 25th hospital day the patient was presented at Medical conference and it was felt at that time that the patient should be put on a high protein intake and his antibiotic therapy temporarily discontinued.

The clinical impression was that this patient had Kimmelstiel-Wilson's disease with pyelonephritis. There was no explanation at this time for his G.I. bleeding. Whole blood therapy continued, including 200cc of packed RBC's which was given on the 29th hospital day. In the evening of the 29th day, the patient suddenly developed signs of respiratory embarrassment and crepitant rales were present throughout both

lung fields accompanied by wheezing breath sounds. The patient was fully digitalized; Ceditanid, Mercuhydrin and aminophyllin were given with some appreciable improvement in his condition by 7 PM.

Heart sounds

By the 30th hospital day the patient became very restless and respiratory difficulty re-occurred. His blood pressure was 130/80, rales and wheezing were present. The heart sounds at this time now became irregular. EKG showed atrial fibrillation and low voltage. Chemistries showed a BUN of 54, creatinine of 4.4, sugar 125, chlorides 128, potassium of 5.2. The patient was given 5% glucose and water.

On the 32nd hospital day there was some improvement in the patient's condition following digitalization.

On the 43rd hospital day the patient's hemogram showed a hemoglobin of 7.3 gm, 46%, RBC 2.8 million and WBC of 13,000. By the 45th hospital day Kussmaul type of respirations were noted. Blood pressure at this time was 145/80. Albuminuria and occult blood in the stools still persisted. His CO_2 was 23 mEq/L, chlorides were 97, sodium 128, potassium 4.2

and BUN was 49 mgms at this time. On the 46th hospital day urine cultures reported proteus; his erythromycin was discontinued and Furadantin, 100 mgms q.i.d., was started.

Over the next 12 days (a total period of hospitalization: 57 days) the patient's course rapidly deteriorated. For the terminal part of his stay it was felt that the patient actually had the full clinical picture of Kimmelstiel-Wilson's disease with supervening vascular and neurological changes with cardiac and renal failure complicated by pulmonary edema occurring prior to his demise. He expired at 7:03 AM on 2-12-58.

Throughout his second Norwalk Hospital admission his temperature averaged between 97 and 99° with a periodic spiking, the maximum of which occurred on February 1, to 103.4 and 101.2 on 2-11.

Discussion

DR. MATTHEW LOCKS, Senior Attending in Medicine: Firstly, patient had an infected lesion of his back resected approximately six months before his admission to X Hospital. It was an infected sebaceous cyst. Shortly thereafter, in the ensuing six months, he had the symptoms suggestive to the compression of

ADDITIONAL LABORATORY DATA

BLOOD	12-18-57	12-27	12-30	12-31	1-30-58	2-10
RBC	3.56		2.33	2.41	3.50	3.10
Hemoglobin Gm%	10.4	5.4	7.3	6.9	10.4	9.6
WBC	8800				10,700	33,300
Polys	66				74	70-23 stabs
Lymphocytes	31				19	7
Monocytes	1				5	
Eosinophils	1				1	
Basophils	1				1	

URINE	12-18	12-23
Appearance	yellow	
Reaction	7.	
Sp. Gravity		1.009
Albumin	2+	4+
Sugar	neg.	neg.
Acetone	neg.	neg.
RBC/HPF	8-12	10-30
WBC/HPF	2-3	14-16
Casts/LPF	0	0

BLOOD CHEMISTRY	12-19	12-23	1-26	1-2	1-4	1-9	1-16	1-24	2-2
BUN	120				44	44	54	52	77
Sugar, Mg %	132					155			
Total Protein, Gm %					4.9			5.6	
Albumin, Gm %					2.3			2.0	
Globulin, Gm %					2.6			3.6	
CO ₂ , mEq/L	29	27	21	30	27			27	24
Cl, mEq/L	81	77	76	92	95			95	93
Na, mEq/L	126	120	107	137	132			130	132
K, mEq/L	4.9	4.5	4.3	3.5	4.00			4.4	4.0
Calcium, Mg %						8.7			
Inorganic P, Mg %						4.8			
Total Cholesterol						170			

LIVER FUNCTION TESTS

S. Bilirubin, Mg %	0.4
Cephalin Floc.	2+
Thymol Turb.	1.4
Alk. Phosphatase	16 K.A.

the spinal cord; namely, he had progressive weakness of his lower extremities to the point where he could no longer walk; he had episodes of incontinence; and he had discoordination of the fine movements of the hands, localizing to some extent the height of the lesion.

On neurological examination at the hospital, he had corroboration of compression of the spinal cord in that he had hyperactive deep tendon reflexes and a Babinski on the left. A spinal fluid tap showed an elevation of his spinal fluid protein to 173 mg. percent. To my mind, at that point, the diagnosis of a spinal cord syndrome due to a tumor at the level of C6, or C7 or C8, or an epidural inflammatory lesion, either tuberculous or some other inflammatory agent, was present.

Myelography

According to the summary, he had two attempts at myelography at that time. The first, apparently was unsatisfactory although a suspicion of a lesion at C7 was seen, and several days later a repeat myelography indicated "the presence of an osteophyte." We don't have those films available and there is some question of whether this thing was done, I

learned. But I will have to follow the protocol as to these examinations having been done and some defect in that area seen containing calcium and at the level where this man had some localizing neurological symptoms.

Following these two procedures, a dramatic change in this man's course occurred. Firstly, he became febrile; secondly, he became increasingly weak, and thirdly, he developed hematuria.

One other thing I did not mention is that this man had incontinence which so frequently goes with a spinal cord syndrome.

Apparently he must have had enlargement of the prostate by rectal examination even though it is not described, because they felt to some extent his symptoms were due to prostatism. At this point in his history, because fever, apparently blood cultures were done and a staphylococcal septicemia first disclosed. He received many antibiotics. He also received steroid therapy at this point and he apparently improved clinically. His blood cultures after this time were apparently negative, but he experienced an episode of gastrointestinal bleeding, presumably due to steroids, so that this form of medication was withheld.

In the protocol it is stated, that there was a suspicion that this man had some form of collagen disease, as demonstrated on skin and muscle biopsies. Apparently there is no description about the findings of these biopsy specimens and I would assume that the steroid therapy was given because of the suspicion of collagen disease.

In reviewing his history up until now, the thing that impressed me most was that this man had an infected lesion of his back resected. Secondly, he developed a focus in his cervical spinal cord with compression; thirdly, after several manipulations of his spinal canal with myelography, he developed an acute febrile illness which is characterized, at least objectively, with a staphylococcal septicemia.

He has no findings to suggest that he has an acute staphylococcal bacterial endocarditis.

Apparently he has no heart murmurs and, as you well know, this type of disease is rather progressive because, the staphylococcus being an ulcerative type of organism, it would cause marked changes in whatever valves would be involved. And we have no evidence, at any point, that he had changes in his valvular sounds. I would assume that this

man had, from the summary to date, a staphylococcal osteomyelitis of his cervical vertebrae with compression; that this was a chronic indolent localized lesion, and that following the changes in dynamics of his fluids and the myelography that was done, he developed a suppurative phlebitis in that area, and following that a dissemination of staphylococci.

Anemia

Somewhere in the summary it is mentioned that he developed an acute inflammatory lesion of his left humerus with abscess formation and this could also well be a suppurative focus in the humerus. Now from that point on this man deteriorated a great deal. He had a suprapubic cystotomy done because of his urinary difficulties. He developed a host of urinary organisms complicating his urinary function, for which he received many antibiotics as well. And I would like to discuss, rather than review the rest of the case, the cardinal problems that were presented in this man.

First of all, he developed a profound anemia. This appears in several places in his course. The nature of the anemia was such that it could have come from several sources. He had gastrointestinal bleeding not only dur-

ing the initial illness at X Hospital, following the introduction of steroids, but he continued to bleed from his gastrointestinal tract throughout the remainder of his life, as evidenced by positive guaiac on his stools.

At no point in the investigation can we localize a lesion of the gastrointestinal tract; he had an upper G.I. Series with visualization of his small bowel and also part of the ascending colon without demonstrable abnormality. Secondly, this man had a sepsis. He had a chronic infection, I feel, over a long period of time. This in itself can contribute in no small measure to an anemia. Thirdly, he had periods of rather severe uremia, his urea nitrogen being elevated over a period of several weeks initially and then falling to not quite normal limits and then a recurrence of the rise.

It is true that during periods of uremia there can be a rather severe anemia present. This has been corroborated very neatly in doing bilateral nephrectomies in rabbits. Very shortly after the nephrectomies a profound anemia ensues without any external or internal hemorrhage and, characteristically, there is intense erythro-phagocytosis demonstrated in the tissues of the autopsied animal.

Against any other sources of anemia such as blood dyscrasias or aplastic anemia due to drugs such as Chloromycetin, of which this man had considerable amounts, myeloma, which to my mind was not substantiated in the protocol, is an absence of the corroborative diagnostic studies or indications during this man's study.

Renal lesion

The second thing that appeared a problem was the nature of the renal lesion in this case. Firstly, he had, to my mind, a cord bladder and prostatic hypertrophy which comprised his renal function. He had a suprapubic cystotomy with the coincidence of exogenous infections in the urinary tract. He never had any anuria, to my mind, so that I could not conceive that he had any involvement of the major vascular channels leading to both kidneys and most important, to me, is that this man had a reversible renal lesion.

Inasmuch as he was in such intense uremia over a period of weeks, with a urea nitrogen as high as 163, and then reverted to the point where his urea fell to 44, whatever lesion he had had to be reversible.

The only reversible lesions I

could think of were an inflammatory lesion, a bilateral involvement of both kidneys with pyelonephritis, or multiple abscesses which, under the influence of all of these antibiotics, healed or at least partly healed.

It is of interest that during the course of his stay here he had a salt losing syndrome in that if you review his electrolytes, he had very low sodium, very low chlorides, no acidosis and his potassium was fairly normal. And it is of interest that shortly after corticosteroid therapy was instituted in this hospital not only was that all corrected, but he had an increase in his chlorides beyond normal. A salt losing lesion is seen in pyelonephritis in certain instances and it would fit the clinical picture.

Though he had albuminuria, he never had any demonstrable casts. I am thinking in terms of a chronic glomerulonephritis or a Kimmelstiel-Wilson syndrome where these findings are usually so common. And finally, he had a normal intravenous pyelogram as was demonstrated at X Hospital, ruling out polycystic kidney disease or other structural disorders that we can rule out with an intravenous pyelogram. I thought briefly about amyloid disease of the kidneys and discarded

it as a possibility, first thinking about it because of the presence of chronic infection but discarding it because of the reversibility of the renal lesion. To my mind amyloid deposits in the kidney do not disappear.

Bleeding

The next problem was the gastrointestinal bleeding. This man had steroids which could certainly cause ulceration and bleeding. He was in uremia certain periods of time and so frequently one can get a uremic gastritis which can bleed severely or a uremic colitis. The absence of findings on x-ray, to my mind, rules out the neoplasm, although the lower colon was never visualized and we may have some coincident finding to explain his continued blood loss.

The possibility of inflammatory lesions in the bowel I stipulated; the possibility of staphylococcic abscesses; the possibility of mycotic aneurysm with bleeding can be entertained. I mentioned the staphylococcus septicemia, the most likely cause being the osteomyelitic focus. The possibility of endocarditis is hard to entertain. His demise is characterized by repeated respiratory embarrassment very strongly suggestive of multiple pulmonary embolism.

He developed atrial fibrillation and heart failure. My feeling is that his death was due to repeated episodes of pulmonary emboli in a man who has been debilitated with chronic illness and bed ridden for a period of ten months. One question I raise in my mind is whether this man really had diabetes. It is of interest that in spite of all his illness, his blood sugars remained within normal limits and to my mind if he did have diabetes it was of quite a mild nature.

Summary

In summary I would say that my diagnosis would be a staphylococcal septicemia based on an osteomyelitis of a cervical vertebra, with compression of the cervical spinal cord. Secondly, multiple lesions of both kidneys due to inflammatory processes either due to the staphylococcal abscesses or due to ascending infection from the urinary bladder, malnutrition, with hypochromic anemia and his final demise due to these pulmonary emboli.

DR. GIARDINA: X-rays from X Hospital consist of examinations of the skull, the chest, left shoulder, the G.I. series and an IVP. I won't show you the G.I. series which appears to be entirely normal. The IVP is normal also.

The kidneys showed up unusually well. The ureters are well demonstrated with no evidence of any abnormality of the urinary tract. The film confirms the fact that he had a myelogram because there is residual pantopaque in his lumbar subarachnoid spaces.

QUESTION: May I ask the date on the IVP?

ANSWER: September '57.

Films

The skull films were entirely normal. The cervical myelograms, two of them as has already been stated, are not available because they were not included in the films given to us. I have a series of chest x-rays taken at X Hospital, the first being August. Views show entirely normal lungs. The heart shows a little prominence of the left ventricle, but it is certainly not very striking.

A repeat film, taken September, is AP film. The heart would naturally look a little larger because of technique, but I think there is essentially no change. There is an incidental finding of two little calcifications here at the periphery of the right lung. These may be old healed tuberculomas or that may be actually outside the lung. It is hard to say; it is so close to the periphery.

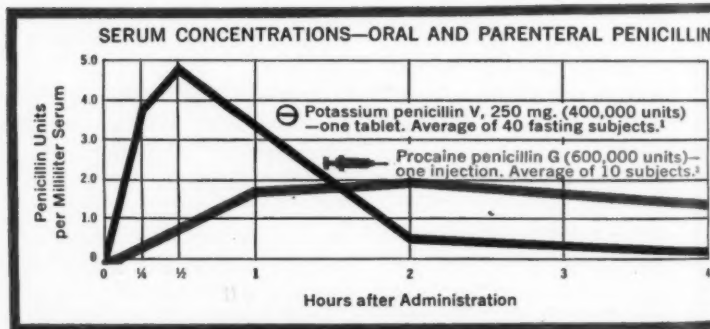
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1. Peck, F.B., Jr., and Griffith, R.S.: Antibiotics Annual 1957-1958, Medical Encyclopedia, Inc., p. 1004. 2. Wright, W.W., and Welch, H.: Antibiotic Med. 5:139 (Feb.) 1958. 3. White, A.C., et al.: Antibiotics Annual 1955-1956, Medical Encyclopedia, Inc., p. 490.

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TABLETS



Philadelphia 1, Pa.

Another film taken in October '57 still shows no change in the heart or lungs.

Now, the left shoulder was examined in September and did not appear to be remarkable except for a small soft disc of calcification which is peritendinitis or calcified bursitis. However, on the subsequent films beginning in October, at the time he had this staphylococcal septicemia, you begin to appreciate an area of early rarefaction immediately above the greater tuberosity of the humerus, right in this area. It was at this time that the patient clinically had an abscess drained—and I must confess that with that sort of a history this is certainly compatible with an osteomyelitis of the humerus. Now as time went on this did not get worse but there was some improvement in the appearance of his defect. You can see cortex on the film in December where you could not back in September; so I agree that the changes in the left humerus are compatible with an osteomyelitis of a very low grade.

The last set of films on this patient are the ones taken here at the Norwalk Hospital the day after admission. A chest film showed essentially the same findings as his previous films did at

X Hospital, nothing abnormal demonstrated in either lung.

The last film we had is a portable film on the tenth of February of this year, 12 days before he died and now there is evidence of pulmonary edema.

The lung bases are probably clouded due to some effusion. The heart is difficult to appraise because of the density in the lung bases, but there is probably little bit of enlargement compared to the previous examination. So our feeling is that it is heart failure now with pulmonary edema. Whether part of this is due to renal disease, which is possible, I can't say.

DR. LOCKS: There is one other thought that I had about this man with a large prostate and the presence of what I felt was an osteomyelitis in the cervical vertebra. There is a very interesting finding with patients who have disease of the prostate with paradoxical metastases, either tumorous or infected, producing changes high up in the cerebral spinal channel because of the connection of the vascular pathways of the plexus in the pelvis with the blood pathways of the spinal cord. One of the things that entered my mind with this man is whether he had some prostatic disease, either inflammatory or

neoplastic, which caused this lesion to appear in the superior portion of the spinal cord.

Diabetes

DR. HOWARD ENTE, Associate Attending in Medicine: I'd like to raise the question whether the diabetes is not really a very significant part of this. I'm impressed by the fact that in diabetes the occurrence of urinary tract infection is very common and also, and I think Dr. Margold will probably agree, they represent very stubborn problems. They sometimes are very persistent and chronic with either infection in the bladder or pyelonephritis, as Dr. Locks has mentioned. The other thing, too, is that in diabetes occasionally one sees what has been called terminal papillitis or hemorrhagic papillitis, which seems to be a specific hemorrhagic disease of the kidneys in relation to diabetes. I am also impressed by the fact that occasionally patients with diabetes can get neuropathy and I wonder whether a transverse myelitis or some process occurring in the nature of a neuropathy in relation to the cervical spinal cord here might not be a diabetic neuropathy. And so I just raise the question of whether the diabetes is perhaps

really the underlying cause with superimposed difficult renal infection, perhaps papillitis, and also the question of whether there is not spinal cord involvement secondary to the diabetes.

Infection

DR. ALLEN MARGOLD, Attending in Urological Surgery: I would just like to confine my comments to the protocol in reference to the urinary tract. I see nothing in here, there is no comment as to a physical examination or a rectal examination that will tell whether this man has a large prostate. I will definitely agree that he has some neurogenic symptoms and it is conceivable with the statement in here that this man had progressive and increased retention of urine; that somebody was passing catheters on this fellow and with the repeated passing of a catheter, repeated infection is very apt to occur.

This man was 53; he was in the early prostatic age, but not the real prostatic age. But he did have neurogenic disease. He had weakness, he had paralysis of his lower extremities, and a neurogenic bladder. Neurogenic bladder is the type of bladder that is very prone to infection, particularly where someone is investigating to see how much the retention

is increasing. Or maybe he just had overflow, and if he had overflow, with a lot of retention, he certainly was a great candidate for an infection in his bladder and an ascending infection. I certainly agree with Dr. Locks his upper tract is probably based on a pyelonephritis with repeated attacks of infection and probably multiple abscesses in the tip, and I think that is why you had the increase in his nitrogenous retention and then with antibiotics it probably improved.

Bowel

DR. ZEPH LANE, Assistant Attending in Surgery: I would also like to carry on with Dr. Margold's remarks. If a rectal had not been done and this patient had precipitate drop in his hemoglobin and red count upon several occasions and definitely has gastrointestinal bleeding, without proof of varices, cirrhosis or an ulcer, either in stomach or duodenum, then we must suspect something in his bowel: diverticulitis, carcinoma and perhaps even a carcinoma which has extended to the bladder walls, such as carcinoma of the rectum, which could produce many of the distal obstructive symptoms of the bladder neck.

DR. LOCKS: One comment about

the consideration of the spinal cord lesion. I, too, thought of a neuropathy, but the sequence of events in this protocol was that this man was in the hyperactive state so far as his deep tendon reflexes were concerned. When first examined, and later on when admitted to this hospital, he already had complete flaccid paralysis and so frequently the course of events is that in spinal fluid compression: first compression, then thrombosis and edema of the spinal cord itself.

DR. L. HERBERT SKLUTH, Attending in Cardiology: The only comment I'd like to make is I think that this man presented the terminal picture of a uremia as the terminal stage of a Kimmelstiel-Wilson process in a diabetic. But I'd like to know the length of time it would take for an amyloid condition to produce it in the presence of suppuration. I imagine it would be much longer than this man's history; but I was wondering if a chronic infection and an acute amyloid condition could produce a thing like pus in the kidneys.

Collagen

DR. ROY BARNETT, Attending in Pathology: I will open the discussion now to Dr. Clark.

DR. EUGENE CLARK, Assistant

Professor in Medicine, NYU-Bellevue: I would not hazard a diagnosis to cover this entire complex situation. I don't know of any single pathological entity that can encompass all the varied manifestations of this case. So much of pertinence has already been said that I would simply add some things that occur to me which may or may not be relevant.

I don't like to ignore findings of pathologists and there were biopsies done in this case interpreted as suggestive of collagen disease. I recognize it is very difficult to explain the entire picture on the basis of a collagen disease as lupus erythematosus, but in view of the biopsy finding I would not like to reject it categorically or forthwith.

First, it is well known that fluctuating or reversible uremia is a part of lupus erythematosus. The degree of renal insufficiency may vary considerably from day to day, or from week to week in this condition. Other than the renal insufficiency in favor of lupus erythematosus perhaps is the obscurity of the entire clinical picture. We do, to be sure, have other things which go with lupus erythematosus; namely, anemia and effusions into some of the serous sacs—the pleural sacs.

The patient with lupus erythematosus is susceptible to infections with pyogenic cocci and that might be an explanation of the length between the staphylococcal septicemia and a collagen disease in this case, if one had to grope for such a length. Actually, it is unnecessary since there was a ruptured sebaceous cyst with chronic inflammation which might very well serve as the portal of entry for the staphylococcus.

If these biopsy lesions are to be ignored or disproved as representing those of collagen disease, what then would they represent? In that connection I would merely raise the possibility that perhaps this patient did receive considerable penicillin when he underwent surgery for the infected sebaceous cyst.

Penicillin

There have been vascular lesions simulating lupus erythematosus seen in those who have received penicillin, quite similar to those seen in serum sickness.

If this should not prove to be lupus erythematosus, I would raise the possibility that the biopsy findings might have been the aftermath of a penicillin reaction.

In that connection, too, we have seen neurological pictures

with penicillin reaction very comparable to that seen with serum sickness. I don't think that it is pertinent in this case to dwell upon that since the neurological picture in this patient seems to be more that of an obstructive lesion than the type of Guillain-Barré syndrome that is seen with serum sickness or penicillin reaction.

Pathology

Dr. Marvin Chernow, Associate Pathologist, illustrated his remarks with Kodachromes.

DR. CHERNOW: At autopsy of the general body organs a bilateral pleural effusion of 2000cc's of yellow watery fluid was found in the right hemithorax and 800cc's of similar fluid was present in the left hemithorax.

There was considerable compression atelectasis of the lungs due to the increased fluid content within the thorax. The mediastinum had a globular configuration. The pericardial sac was a dull yellow color. On exposing the pericardial cavity, a hemorrhagic-purulent exudate, partially organized, was present. The liquid component totaled 90cc's.

Postmortem culture of the pericardial contents yielded hemolytic staphylococcus aureus: coagulase positive. The heart weighed 430

grams. The valves were unremarkable. There was no evidence of valvular vegetations present. The myocardium throughout was flabby in consistency and hyperemic in appearance. The peritoneal cavity contained 700cc's of yellow watery fluid. And hepatosplenomegaly was present.

The spleen weighed 670 grams. On sectioning the splenic parenchyma had a semi-liquid consistency. Grossly the pancreas and kidneys were unremarkable. The urinary bladder was a contracted, thick-walled organ. There was elevation of the floor of the bladder with a ball valve obstruction of the internal vessicular orifice due to marked lateral and median lobe hypertrophy of the prostate. The latter weighed 40 grams.

Exploration of the gastrointestinal tract failed to reveal any recent or healed areas of ulceration in the upper G.I. tract. However, in the sigmoid colon the lumen contained black fecal matter which on removal revealed deposition of fibrin on the mucosal surface.

Microscopic findings

Sections of pericardium (Fig. 1) showed an organized inflammatory exudate comprising the

Figure 1

Figure 2

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Figure 1

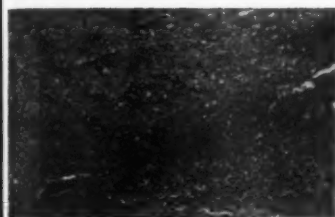


Figure 2

deeper layers involving the epicardium while more superficially the reaction was acute in type.

Brown-Brenn stains (Fig. 2) showed aggregates of gram positive cocci in the superficial layers of the pericardium. Within the myocardium there were aggregates of polymorphonuclear leukocytes seen independent of the vessels.

The lungs (Fig. 3) showed passive congestive changes and sections of the tracheobronchial lymph nodes revealed complete calcification of the nodes.

Sections of spleen revealed focal deposition of hemosiderin and an increased number of poly-

morphonuclear leukocytes within the sinusoids.

The pancreas revealed intact and rather well preserved acinar and islet structures although foci of squamous metaplasia of the duct epithelium was seen in one area. The liver showed severe passive congestive changes. The kidneys showed scattered foci of interstitial inflammatory infiltrates composed of plasma cells and lymphocytes (Fig. 4).

The nephron units were well preserved. There were no stigmata of diabetic glomerular sclerosis seen. The larger renal vessels showed arteriosclerotic changes. Sections of large bowel revealed superficial necrosis of the mucosa with fibrin and polymorphonuclear leukocytic exudates.

Grossly the most striking finding within the brain was severe arteriosclerotic involvement of the basilar artery and cerebral vessels. On histological examination the basilar artery contained a large subintimal atheromatous plaque with marked encroachment into the lumen of the vessel (Fig. 5).

Sections of cerebrum, cerebellum, pons and medulla revealed small areas of "paling" and acellular foci with and without glial cell reaction. Representative

sections of peripheral nerves taken from the lumbar plexus as well as random sampling of skeletal muscle and skin failed to reveal any evidence indicative of that broad group of diseases termed "collagen disease."

Diagnosis

In summary this patient died in congestive heart failure secondary to a fibrino-purulent pericarditis and myocarditis following a staphylococcal septicemia. As for his early neurological findings, I think this is compatible with his severe cerebral arteriosclerosis and septic state. His urinary retention was due to a severe median bar obstruction of the internal urethral orifice necessitating a cystotomy.

DR. BARNETT: In summary, this patient had three almost independent disorders. First, and the apparent cause of the presenting CNS symptoms, is the severe arteriosclerosis of cerebral vessels, doubtless related to his diabetes. The fluctuating nature of these manifestations is much more characteristic of arteriosclerotic narrowing than of any pyogenic lesion causing intrinsic or extrinsic spinal cord pressure.

Second was the *Staphylococcus aureus* septicemia, apparently initiated by diagnostic manipula-

tions. This type of infection has become the bugaboo of the modern hospital. The infection localized in the pericardium and to a lesser degree in the myocardium and I feel this is the direct cause of death via heart failure.

Third was the pyelonephritis resulting from benign overgrowth of the prostate. This was under good control following cystotomy

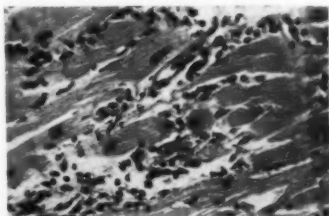


Figure 3

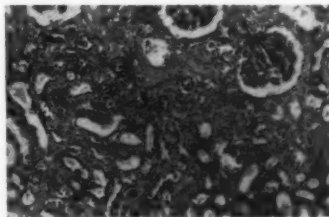


Figure 4

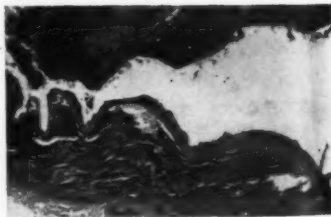


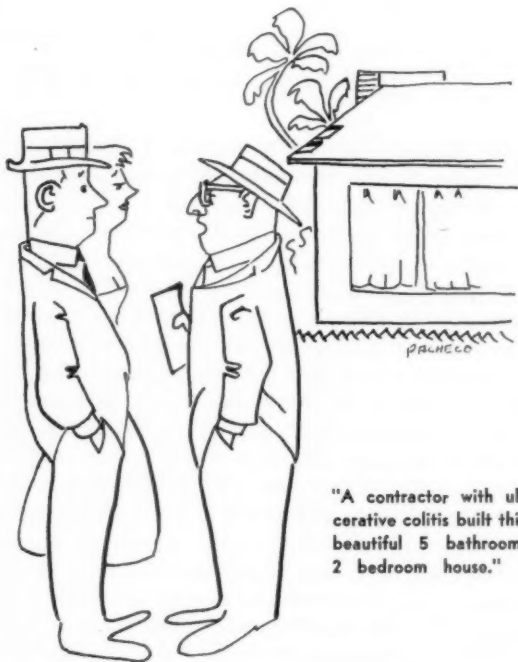
Figure 5

and was not directly concerned with his death.

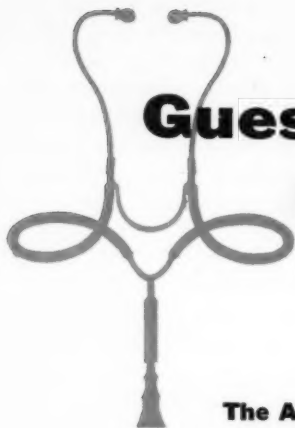
The occurrence of multiple major diseases in older persons is actually the rule rather than the exception. Particularly in this instance the arteriosclerosis and the sepsis are both common compli-

cations of diabetes and are not really unrelated.

I have reviewed the skin and muscle slides from which the diagnosis of "collagen disease" was made and believe these were non-specific degenerative changes, common in wasting diseases.



"A contractor with ulcerative colitis built this beautiful 5 bathroom, 2 bedroom house."



Guest Editorial

The American Hospital as an Ambassador of Good Will

The 112th president of the American Medical Association, Dr. Gunnar Gundersen, of La Crosse, Wisconsin, declared in his inaugural address: *"Medicine has a role not only in promoting better world health, but also in helping in the search for brotherhood and peace."*

It has occurred to us many times what a great opportunity medicine has, at the present time, to make an outstanding contribution towards international relations through education. Currently, there are more than 7,600 physicians in the United States from foreign lands pursuing graduate education. These men and women will return to their native countries and will take back with them not only gained professional knowledge but deep rooted impressions of America and Americans.

We should seek and welcome graduates of foreign medical schools who have qualifications and capabilities comparable to the standards established by the Council on Medical Education. When they do enter our hospitals, we must do the best possible job for them from

the standpoint of their education as well as their potentialities as good will ambassadors for American Medicine and democracy..

At the recent annual meeting of the American Hospital Association, it was reported that a great number of those physicians returning home have expressed disappointment in their experience in the United States. This impression must be changed. First, all hospitals and their medical staffs must exert every possible effort to establish sound educational programs for graduate students. A primary premise suggests that proficiency in teaching is a special skill and not related to seniority of staff position.

Secondly, there must be created in the hospital setting a university atmosphere. A desire to impart knowledge must be genuinely stimulated. There must also be developed, on the part of the student, a strong appetite for medical learning.

When educational programs are strengthened and a favorable atmosphere created, the major sources of disappointment in their experience will be lessened if not totally removed.

Because these physicians come from areas of different customs and cultures, it is incumbent upon us to accept them on a friendly, cordial and equal basis. Every opportunity should be afforded them to understand the American way of life. Opportunity to visit American homes socially is one method. Visits to other hospitals, medical centers, universities, conventions, as well as attendance at museums, theaters and other cultural areas should be encouraged. Each or all of these and other methods will provide a free exchange of viewpoints, and through the medium of social, educational



ALLEN M. MARGOLD

Director of Urology, and Director of Medical Education, Norwalk Hospital.

and cultural contacts, a better understanding between the people of our country and those who come to us will be developed.

The avowed objective of the profession of medicine is the common good of mankind. If by these and other progressive means, Medicine accepts the challenge, each year there will be returning to their countries of birth, 3,000 or more physicians who will be leaders in medicine and education. These individuals will serve as good will ambassadors for American Medicine and democracy.



"I wish I had 20/20 hindsight like that pathologist."

A GUIDE for our readers

The conventions of the presentation of advertising material on pharmaceuticals are related to certain ethical and practical considerations. This guide should be of help to all our readers in an understanding of the advertising material contained herein. Unless it is stated to the contrary:

All illustrations of physicians and patients are dramatizations utilizing models and not specific physicians or actual patients. The ethical and other considerations for this are obvious.

Illustrative material such as dummy prescription blanks, hospital charts, calling cards, memos, etc., are presented as dramatizations.

Composite case histories, drawings and/or photomicrographs are often presented to convey typical clinical indications but unless stated to the contrary are constructed as illustrative cases or situations.

Physical limitations of space in journal advertising make the presentation of all relevant data impractical; therefore, it is suggested that for suitable background on dosage indications and contraindications the standard package insert or more extensive background data be consulted.

The acceptance of material for advertising is based upon several criteria; for example, in respect to safety, all new drugs are required to correspond with the accepted Food and Drug application.

It is suggested that any differences of opinion of individual physicians with any advertisements be called to the attention of the editor, with a duplicate copy of the letter to the pharmaceutical house whose advertisement is the subject of the letter.

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*Effective clinically in upper respiratory infections,
pneumonias, soft tissue infections, bacteremia/septicemia,
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Effective in vitro against the following organisms
(isolated from clinical infections listed above):

Organism	Sensitive	Resistant	% Sensitive
Staphylococci*	181	1	99.4
Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
Coliforms	34	3	91.8
Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

*Includes many strains resistant to antibiotics.

As with all nitrofurans in years of extensive clinical use, there is little or no development of bacterial resistance with ALTAFUR.

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the chief residents in surgery at
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Charity Hospital of Louisiana
Ohio State University Hospital
Strong Memorial Hospital
discuss their services,
how they are organized and managed

UNIVERSITY OF ALABAMA MEDICAL CENTER

Frank A. Berg, M.D.

The author received his M.D. in 1953 from Hahnemann Medical College. He completed his internship and residency at University Hospital of the Medical College of Alabama in Birmingham, Alabama. Dr. Berg is presently an instructor in surgery at the University of Alabama Medical College.

To compare our service with those of other teaching hospitals one needs to know a little about our general organization. We have four chief residents who work in pairs. Each pair spends six months at the University Hospital, a 600 bed general hospital with 240 charity beds, and six months at the Birmingham Veterans Administration Hospital, a 450 bed hospital, 80 of which are general surgery. The hospitals are across the street from each other and since the Veterans Hospital is a Dean's Committee Hospital, the surgical service there is run the same as that at the University Hospital in almost all aspects.

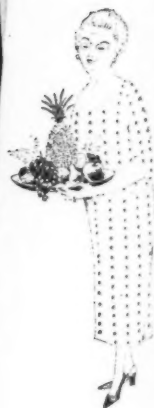
Although the service is run by the chief resident, he is di-

rectly responsible to the chief of service. It is his responsibility to see that the chief of service is informed of all major problems.

We believe that, in addition to other factors, good patient care means adequate use of senior consultation on all levels *wherever* needed. There seems to be a natural tendency among the junior residents not to seek consultation as often and as early as they should. We feel that a resident may handle as many problems as he is capable of handling at his particular level without necessarily seeking consultation. However, it is inexcusable not to seek consultation when in doubt, or with major problems. Most problems are handled at the resident level.



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**the full-range oral hypoglycemic agent...
lowers blood sugar in mild, moderate, and
severe diabetes, in children and adults**

FOR MORE DEPENDABLE RESPONSE, start your patients on DBI—entirely different from the sulfonylureas in chemical structure, mode of action and spectrum of activity... usually effective in low dosage range (50 to 150 mg. per day).

3 out of every 4 stable adult diabetics are satisfactorily and comfortably regulated with DBI.

2 out of every 3 brittle diabetics (juvenile or adult) enjoy better stabilization and easier management with combination of DBI and injected insulin. The smooth, gradual onset of blood-sugar lowering action helps prevent dangerous shifts between hypoglycemic reactions and hyperglycemic ketoacidosis.

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no clinical toxicity in over 3000 patients studied closely for varying periods up to nearly three years.

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Consultation

Consultation with other services is handled primarily by the chief resident. Certain routine consultations are delegated to the junior residents. Consultations at night are seen by the senior resident first before calling the chief resident. Complicated cases are usually presented to the attending man or the chief of service by the chief resident.

Attendings

Most of the problems the chief resident has on the ward can be solved with the help of the attending men. The attending man makes complete rounds in the ward with the chief resident at least twice a week seeing every patient, in addition to bedside consultations as necessary.

They do not see every patient going to surgery, only those with particular problems. It is understood that the attending man should know about problem cases before surgery, and unless asked by the resident, the attending man makes the decision as to whether he should see the patient.

At nights the attending man will upon request see a patient with us, but usually a telephone consultation is adequate. When the attending man is called, it is usually by the chief resident.

Procedure

Each patient is seen by a student, intern, junior resident, and senior resident at least twice each day. The student and intern have a history and physical on each patient. Each patient has an admission note by at least one of the residents. Complicated cases are seen by the chief resident at least once daily.

Notes

Daily notes are written by the medical students on all except chronic cases. Notes are made by the house staff as often as is necessary depending on the progress of the patient. Preoperative notes are made by the operator the day before surgery. In addition to the dictated operation report, a written operative note is made by the operator. Each chart has to have a discharge note by one of the residents on the ward.

Residents

The third year residents at our hospital have most of the direct responsibility in running a ward. They do much of the major surgery and make most of the decisions with the aid of the chief resident. As we always have a third year resident on duty and in the house, the chief resident

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depends upon the third year man to keep him informed of all major problems. The chief resident usually handles the administrative problems the third year man may have on the ward with nursing, laboratory, etc. On the other hand, the resident helps the chief resident in carrying out the service's policies.

Interns

We try to see that the interns do not have too much "scut" work and are getting an adequate amount of surgical training. Often, with eager junior residents, the intern may not get to do some of the work he is capable of doing. It is also for the good of the next year's intern program that the intern should feel he has had a chance of obtaining a fair amount of surgical experience. The hospital administration also requests a monthly evaluation of the interns on the surgical service.

Medical students

The chief surgical resident is expected to have a fair idea of the capabilities of the students assigned to his area. The distribution of cases and ward work by the medical students is overseen by the chief resident. Students will often come to the chief resident with complaints about the

ward before they would complain to the third year man in charge of the ward.

Nurses

Conflicts between the man running the ward and nurses on the ward can usually be ironed out by the chief resident and the nursing staff without appealing to higher authorities. Administratively we do not have many dealings with the student nurse, except when she is holding down a responsible ward nursing job.

Duty schedules

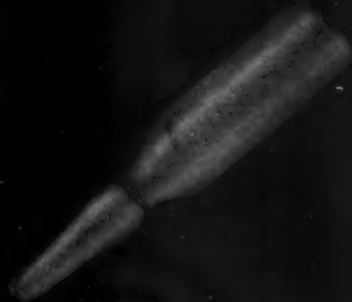
Schedules are prepared by the chief resident according to a master schedule worked out with the chief residents and chief of service. We assign the residents to duty every other night and arrange the schedule so that each ward has one of its residents on duty every night. Our night and weekend coverage in each hospital has a third year resident and a junior resident plus interns and medical students in the house at all times. In addition, the chief residents rotate night call.

Of course we expect every man to take care of his own operative complications when they require reoperation, regardless of the time. Time off does not begin until all patient responsibility for

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the day has been completed. When our men need to leave the hospital during the day, we require that they sign out to someone on their own level who will be able to cover for them and not someone who may have to be in surgery.

Vacation

Vacation time of two weeks is granted to all residents. Vacations are scheduled and staggered by the chief residents. Seniority allows first preference as to selection of vacation time. When medical students are not on the wards we are somewhat short-handed, and we try not to schedule vacations at that time. When the third year resident has his vacation the chief resident takes his calls, and stays in the house when the third year man would have ordinarily been on call.

Most of the elective surgery is done on Monday, Wednesday, and Friday. The chief resident schedules the cases with the OR and assigns the residents to the service cases according to the type case and experience of the resident involved.

Residents have full surgical responsibility. They are allowed to operate without an attending man in the operating room. How-

ever, the attending man, when he scrubs, usually scrubs with the chief resident; in turn, the chief resident scrubs with the senior resident on his complicated cases or new procedures.

In our residency the third year resident probably does most of the routine major cases with the chief resident assisting him until he has obtained sufficient proficiency in a given operation. The chief resident does the surgery on most of the critically ill, and infants, plus the thoracic surgery and cases as needed to round out his experience. Our first year residents have ample experience with elective surgery and emergency laparotomies such as perforated ulcers and abdominal trauma.

Schedule

Along with some of their specialty training, the second year residents are assigned to the private surgical service. During this period on the private surgical service they act as first assistants on all major private cases. There is a private surgery resident in the house at all times. Residents on private surgery are responsible to the chief resident for seeing that the private service runs smoothly.

We have excellent cooperation with the administration. Most of

Resident Physician

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our dealings are with the assistant administrator and his staff: we call on them, and they on us, as problems arise. Usually the problem can be solved without taking it to the chief administrator or the chief of service. Under the present administration, the hospital has made much progress in the past several years.

Cooperation

We receive complete cooperation from the OR supervisors at University and Veterans Hospitals. All our residents agree that the operating suite at the Veterans Hospital must be one of the most efficient in the country, and both hospitals are very cooperative in arranging for emergency surgery for the resident staff.

We have no direct contact with the head nurse, but deal mostly with the surgical supervisor or the head nurse on the ward. In general they are very cooperative, although not as flexible as we would sometimes like them to be as to changing ward routine. However, medical and surgical chief residents have joint meetings with the administration and nursing supervisors to iron out problems as they arise.

As with most hospitals, our biggest problem is that we do

not have enough RN's. The chief resident has the job of smoothing over occasional tiffs between a resident and a ward nurse. Because of the RN shortage, the practical nurse is sometimes doing an RN's duty and then requires more guidance in her work.

Educational

The chief resident is responsible for organizing the weekly surgical conference attended by the staff, residents, interns, and medical students on the surgical service. The conference usually is centered on a problem case, and then the various aspects of diagnosis and management are discussed. The chief resident may conduct the entire presentation, or may ask various staff members to participate in the discussion.

Most of the teaching is informal, and is carried out at the bedside or in the operating room. In addition, charts are reviewed to determine the type of orders and quality of work-ups being written. When a resident or intern is learning a procedure new to him, he should have an experienced assistant. For example, we feel that a relatively inexperienced first year resident should not be teaching an intern to do his first appendectomy.

The chief resident participates

formally in medical student education by taking his turn with the staff in moderating student seminars. The students prepare and give discussions, and then the moderator comments and asks questions. Informal discussions are carried on at the bedside and in the OR.

Student nurses receive formal lectures on surgical subjects by the residents. Assignment of lectures are made by the chief resident, who does some of the lecturing himself.

Grand rounds

We conduct grand rounds every Tuesday morning. This is really the climax of our week's work for this is the time when all patients are brought under the direct scrutiny of our chief. After rounds, a meeting of the attending staff, residents, and interns is held at which a report is read listing all admissions, discharges, transfers, complications and deaths. Deaths and problem cases are then discussed. Approximately three hours are con-

sumed by rounds and the meeting that follows.

The chief resident makes complete rounds with the third year resident at regular intervals. Problems are discussed at the bedside with the intern and residents. Obtaining autopsy permission is usually done by the resident having the best rapport with the family.

The chief resident's philosophy as regards management of a surgical service is usually crystallized in the year prior to his becoming chief. At this phase of his training, he views critically his chief resident's management of the service, and decides how he would like the service run. Actually, there were very few new policies that were instituted when I began my year as chief resident. Our service was well organized in the past, and as I look back on my experience the service today is generally run much as it was four years ago. Of course there have been improvements along the way, and we expect them to continue.

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CHARITY HOSPITAL OF LOUISIANA

Arthur Gene Lawrence, M.D.

The author received his M.D. in 1952 from the University of Chicago. He spent his internship and residency at Charity Hospital, New Orleans, where he trained in internal medicine and general surgery. Dr. Lawrence is presently on active duty in the Army as a captain. Following two years of military service, he plans to return to Chicago and start a practice.

The surgical residency training in our institution has three main characteristics:

- There are three distinct services; the Tulane and Louisiana State University services and the Independent service. The first two each comprise 40 percent of the surgical beds, and the latter 20 percent. These services are covered by separate staffs and function independently of one another. The accident and emergency admissions are handled by a different service each day in rotation.

- Surgical residents accepted

for the first year may expect to complete their entire training, provided their services are satisfactory; this is in contradistinction to the pyramidal system.

- Since this is a charity hospital, all cases are service cases. Thus, the surgical residents assume responsibility for care of all the patients under staff supervision.

Tulane

This discussion applies to the Tulane Surgical service at the Charity Hospital where it was my privilege to serve as co-chief resi-

dent for the year 1957-8 with Dr. Abner M. Glover.

In the first three years there are usually six residents in each group. In the fourth year some of these men are given advanced training in other state hospitals so that none is allowed to go without completing a full four years of training. In these other hospitals the surgical resident is the ranking medical officer and is aided by qualified surgeons in the area.

Assignments

Our service comprises 115 adult beds and 25 pediatric beds (thoracic surgery patients are included in this census). Patients are segregated as to sex and color, providing a convenient means of resident and staff assignment.

On each group of wards are assigned an intern, a first or second year resident, and a third year resident. The ward assignments are, with the exception of the interns, for a two month period. The fourth year residents alternate between the white and Negro services every three months. Each group of wards is also covered by one full time and one part time staff surgeon. These attending men hold ward rounds with the house staff once each week and supervise operative procedures one day each week.

Responsible

Chief residents are directly responsible to the chief of surgery of the Tulane Unit of Charity Hospital. This position was occupied by Dr. Alton Ochsner during my first two years of training and is now held by Dr. Oscar Creech, Jr.

Discussion of the problems of the service, criticism, planning of teaching programs are all handled in part at a weekly luncheon attended by the senior residents and the staff. So-called "service policies" are frowned upon for the most part; rather, the decisions made on a patient are by the staff and residents on a particular ward. Chief residents are given more freedom in this regard, yet are encouraged to consult the staff on problem cases. Interns and residents are responsible to the fourth year resident and consult him in almost all problems before attendings are called, thus giving him an opportunity to participate in the management of more cases and gain more experience in this year than in any of the preceding three.

Ward rounds

The chief resident makes rounds on all wards each day, usually in the afternoon, and all ward personnel are expected to

be present. Rounds by the other members of the house staff are made at least twice each day. Senior medical students assigned to the wards are also required to participate in all rounds and conferences involving their patients. Discussion is encouraged during these sessions on the wards, giving the chief resident a chance to examine his own reasoning as well as that of his subordinates.

Nurses

Graduate nurses are at a premium here as elsewhere. They are seldom available to make ward rounds with the staff. The student nurses have no part of their formal teaching program correlated with that of the residents. Several residents, however, are employed by the school of nursing to give lectures as an extracurricular activity.

Problems involving bed shortages, patient nursing care and the like are ordinarily handled by the chief resident and the supervisor of nurses on the surgical floor.

Schedule

The duty schedule is much the same in all levels of residency training; an average of 12 nights on call each month, one weekend off per month, and a working day from about 7 AM until 6 PM.

This, of course, is variable according to the current case load.

Days on which the Tulane service is "admitting" (caring for all accident and emergency cases) require the presence of all members of the service except those assigned to work the following night.

Accident

The accident and admitting rooms are covered by first and second year residents assigned to this duty as a separate service; these men also run the outpatient department for our service. This allows residents assigned to the ward to spend more time with their patients without interruptions with calls from the emergency room.

Since Charity Hospital is the only hospital in the area with a completely equipped accident room staffed continuously with trained personnel, traumatic cases in large numbers are seen each day. A surgical resident is present at all times to supervise the interns; he is encouraged to consult his senior resident regarding the management of cases. Every case admitted from the accident room is seen by the third year resident assigned to the service to which the patient is admitted. All patients for whom surgery is



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Acute

A separate ward for the observation of acutely ill patients is a special facility in which we take pride. Patients with acute abdominal problems as well as diseases requiring close observation over a period of time, such as burns and tetanus, are admitted here. It has long been customary on our service to err on the side of admitting patients to the observation room rather than practicing watchful expectancy at home.

Supervision of emergency admissions is almost entirely the responsibility of the chief resident. No case can be scheduled in the operating room without his having seen the case and approved the plan of management. He is ordinarily called when the third year resident has seen the patient and has had an opportunity to examine the patient and form his own opinion. Again, interns and junior residents are also expected to work up patients in the observation room and participate in the discussion of the plan of management.

Nursing care in this department is provided by nurses who are alert to the problems of the

acutely ill patient and who can aid the staff in execution of various tasks such as the insertion of nasogastric tubes and the like. Since the space in the observation room is limited (18 beds), it is the responsibility of the chief residents of the various services to see that their patients are moved to the ward as soon as feasible.

"Off" nights (those nights when other services are responsible for emergency admissions) are covered by an intern, a first or second year resident and a third year resident. These men care for any emergencies left from the night before, perform routine ward assignments and (third year man) answer rush consultations from other Tulane services. The chief resident is called at home when any problems arise; this assignment is rotated between the co-chiefs by their own agreement.

Time off

Although all other services are allotted one month vacation during each year, it has recently become the custom on our service to reduce this to a two week period. It is a service rule to bar vacations during the months of June and July since there are always enough unavoidable absences during these months to create a manpower shortage.

Since ours is a charity hospital without private services, there is more material for the residents than is probably the case in many hospitals. Out of an average 3000 admissions to our service each year, 2000 operations are performed. About 90 percent of the operations are performed by the resident staff in a distribution to be mentioned shortly. The interns rotating through surgery for two month periods are expected to learn surgical principles rather than technique; their supervised operating consists of two or three appendectomies, hernias (simple), and amputations.

The first and second year residents spend approximately nine months during these two years rotating through orthopedics (three months), emergency room and clinics (three months), neurosurgery (one month), and admitting room (two months); six months are spent on pathology.

During these two years the emphasis is mainly on pre- and post-operative care and the operations performed are of relatively small magnitude until the last three months of the second year. At this time operating room "privileges" are assigned to cover uncomplicated procedures.

The third year residents are

the most constant common denominators of the surgical service. They perform moderately advanced operations such as cholecystectomies, thyroidectomies, and abdominal explorations for various types of abdominal trauma, intestinal obstruction, etc. During the second six months of the year, they are allowed to do uncomplicated gastrectomies and comparable procedures. In emergency procedures they are assisted by the chief resident and in elective operations by either the chief resident or the staff man on the ward.

They also supervise the junior residents and interns on small procedures.

The major portion of the operations are done by the fourth year resident. Poor risk patients, regardless of the procedure to be done, are operated upon by the chief resident or staff; quality of individual patient care is never sacrificed for the technical training of an individual. Patients operated upon by the attending men generally are those having the more complicated surgical problems. Our staff men are encouraged to demonstrate surgical technique to the residents, but this represents only a small percentage of the total cases.

Ward rounds with the attend-

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ings are generally held with all ward personnel and the chief resident. Although students may attend these rounds, there are separate scheduled sessions for the students alone. Most of these are conducted by the staff. However, once each week the senior students meet with the chief resident for formal ward rounds.

Informal rounds are made daily with the students assigned to the particular ward. The chief of the surgery service makes rounds on one ward each week, so designated by the chief resident for the teaching value of its cases; these rounds serve the dual purpose of teaching the residents and acquainting Dr. Creech with the manner in which the service is being run.

Conferences

In addition to specialty conferences (tumor, gastroenterology, pediatric surgery, which are organized each week by the second or third year residents involved) there is a weekly general surgery staff conference which is planned by the co-chief residents. This is divided into two portions:

- Presentation of interesting cases or subjects for discussion. The experience of the hospital or of the surgical service is frequently reviewed on a particular

subject to give the conference more teaching value. This portion of the conference also serves as a sounding board for staff opinion and lively exchange of ideas is frequently the result. Presentation of "routine" cases for decision is avoided; rather, cases are presented which act as starting points for discussion of general problems. The presence of staff men with varied types of surgical training enhances the value of such conferences.

Records, reports

- The presentation of the weekly report of the service takes place during the second hour. A mimeographed record of the census, operations done (and by whom), complications and summaries of deaths, is distributed to the residents and staff for discussion. Complications and deaths are presented and view critically by both residents and staff. A yearly analysis of these reports is made in an attempt to further improve the quality of care on our service.

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* I. Bickerman, H. A.: *In Drugs of
Choice 1968-1969*, ed. by W. Modell,
Mosby, St. Louis, 1968, p. 562.

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stances. We require a complete work-up on every patient by medical student, intern and junior resident. Progress notes are a subject of constant "nagging" by the chief resident. Inclusion of all diagnosis on the face sheet when a patient is discharged is stressed. Obtaining permission for postmortem examination is sometimes a problem, but with concentrated effort we manage to maintain a necropsy rate of about 70 percent.

Consultation

Routine and rush consultations are answered by the third year residents. They in turn, in other than minor problems, consult with the chief resident for disposition. He may feel it is advisable in certain instances to have staff consultation also.

Regardless of the "admitting day," surgical consultations from other Tulane services are directed to our service. Interservice disputes, when they arise, are handled through the chief residents of the services involved.

With regard to consultations from our own service, it is constantly stressed that the function of the consultant is to bring in new ideas and not act as a substitute for the consultee's own thinking.

A resident on our service is taught and encouraged to be first a doctor, then a specialist; cardiac, renal, and pulmonary problems are managed to the best of his ability before consultation is sought. Thus, by viewing the patient as a whole he is better qualified to single out those who will benefit from surgery.

OHIO STATE UNIVERSITY HOSPITAL

Richard J. Ireton, M.D.

The Ohio State University Health Center has 1400 beds distributed among the University Hospital, Columbus Receiving Hospital, Ohio Tuberculosis Hospital and Children's Hospital.

Selection

The chief resident is selected by the chairman of the department, usually from the 3 or 4 senior residents (fourth year) at completion of their last year.

The author received his M.D. in 1950 from Harvard University. After an internship at Presbyterian Hospital, Chicago, Illinois, he served two years with the U. S. Army Medical Corps in Europe. Following Army service, Dr. Ireton completed four years of residency in surgery at University Hospital, Ohio State University, and there became chief resident in surgery for a period of one year. Since completing his residency, Dr. Ireton has been Chief of Surgery, Veterans Administration Center, Dayton, Ohio.

Since all residents at University Hospital receive academic appointments in the College of Medicine, and are paid by the College of Medicine, the chief resident is appointed an Instructor in Surgery and thus has faculty status.

While the chairman of the department of surgery controls the surgical divisions of the various hospitals, and the chief resident is his representative, the chief resident functions principally in regard to the 218 surgical beds of general surgery and specialty services of University Hospital and the surgical service of the adjacent Ohio Tuberculosis Hospital.

Currently there are 10 first year, 2 second year, 3 third year and 4 fourth year general surgical residents; 2 neurosurgical residents; 2 orthopedic residents, 1 thoracic resident, 3 urological residents, plus 16 interns assigned

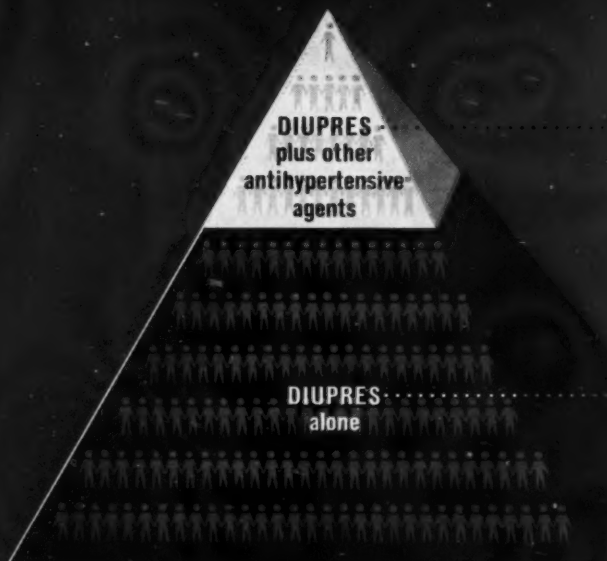
to surgery at any one time, for a total of 43 house staff members under his administration.

Responsibility

The chief resident is directly responsible to the chairman of the department for the implementation of departmental policies and for the combined activities of the surgical house staff. While he may work with various department heads both within the department of surgery and without, he functions in a similar fashion to an adjutant in the Army, and thus his authority arises from and his responsibility is to the chairman.

Residents

The members of the surgical resident staff are responsible to the chief resident. Rotations are established by the chief resident after consulting the residents themselves, full time attending



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staff, and with the approval of the chief of surgery. The night duty roster as well as the vacation schedule is arranged by the chief resident. All problems, in general, clear through the chief resident before going to the chief of surgery.

Interns

The relationship with the interns is essentially the same as the residents except that their service assignments are established by the Intern - Resident Committee, and vacations are decided at the start of the year by a committee to which the chief resident belongs. "Gripes and complaints" are handled by the chief resident as well as emergency leave or illness.

Although teaching obligations will be discussed later, the chief resident administers the entire sophomore surgery teaching program, and assists the two staff men assigned to the junior and senior surgery programs.

The chief resident works closely with the surgical supervisors as well as the hospital administration in solving small problems relating to the floors, patient care, living quarters, and other details not requiring action by higher authority.

Although residents of the spe-

cialty services are responsible to the chief resident, his prime concerns are the general surgical services. At University Hospital these are four in number, of about 30 beds per service. There are two clinical (indigent patient) services, the professor's service and a private service.

A clinical or indigent patient service has a senior resident in charge and a responsible staff man. Further, there is a first or second year resident assigned, two interns, two senior students and four or five junior students.

Clinical

The senior resident on the clinical service decides which patients should be admitted to his service either from his own clinic or the emergency room, outlines their care, decides on the time and type of surgery, and either performs the surgery or delegates it to his junior resident or intern. All this is under the direct supervision of the staff surgeon assigned to the service.

The chief resident has no control over the patients on these services except to see that departmental policies are being followed.

The two private services are run by residents at a lower level with the patient's private surgeon

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¹ Matfield, M. A., Simpson, H. A., and Jackson, H. L.: *J. Pediatr.* 44, 32-45 (Jan.) 1954.
² Frost, L. W., and Jackson, H. L.: *J. Pediatr.* 39, 545-552 (Nov.) 1951. ³ Harrickson, W. E.: *GP* 9: 51-56 (Oct.) 1953. ⁴ Litchfield, H. R.: *Arch. Pediatr.* 61, 417 (Dec.) 1944.

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making all decisions as to patient care.

Thus each service has certain time in the operating room, and certain time in the clinic and is administered by the residents in charge. It is the duty of the chief resident to set up the system, assign and orient the men on each service, and then let the system run itself, entering in only when there is a conflict or a deviation from the plan. The operating schedule, the members of the operating team, and other routine problems are handled relatively automatically.

Duty

Each resident in charge of a service, whether general surgery or specialty, not only controls his own admissions and arranges his own operative schedule, but also is responsible for that service at all times. While there is a night and weekend duty roster, with two junior and one senior resident on duty at all times, they are responsible only for emergency room admissions or floor emergencies; as soon as the emergency ends or the responsible senior resident arrives, he assumes control.

Thus, a patient having an intestinal obstruction may be admitted by the night duty team.

But once admitted, the senior resident on whose service the patient is admitted, assumes full responsibility for patient care. He may delegate some of the responsibility or even the surgery, but he is held accountable. He, of course, relies on his staff man who must approve decisions as to management.

Resident beds

The chief resident maintains a small clinical or indigent patient service of his own. This usually comprises three of four beds on each of the two clinical services. All requests for consultations come to the chief resident and he sees the majority of these personally. From this source of patients, he keeps what surgery he wants, and the remainder goes to the two clinical senior residents. In addition, patients referred in by telephone or letter from outside physicians flow through his hands and he may keep any of these as his own clinical patients.

Rarely, a particularly difficult case may be turned over to the chief resident by one of the senior residents; however, this is not encouraged. Thus the chief resident does not interfere with the patients of the senior residents.

The chief resident's six or eight patients are cared for by

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the junior residents, interns, and students on those services to which the patients have been assigned. The chief resident uses the assigned staff man in consultation and for approval in the same capacity as does the senior resident.

Teaching

The chief resident contributes to the education of the residents, interns, medical students, and nursing personnel at all levels. His main responsibility at resident level is in the operating room where he may teach as he operates or assist the junior resident as he operates, and also at the bedside of his clinical patients requiring major surgery, who are a valuable teaching source. The same opportunity for teaching exists for interns.

In addition, on Sunday morning the chief resident conducts his personal rounds on the clinical services with only the responsible interns in attendance. This gives him not only a chance to provide the intern with a new approach to his patients, but also to ascertain how well the intern is being taught, how well he knows his patients, and further provides a method of knowing exactly what is going on in the service without infringing on the senior resident's authority.

Students

The educational program for the medical students has to do with sophomores, juniors and seniors. The chief resident is in charge of the sophomore surgery program which covers the Fall and Winter quarters. It is a two hour course and involves 150 students. These are divided into multiple groups and are either taught on the various nursing stations by attending surgeons or receive a series of lectures. The assignment of attending men, scheduling, giving the lectures, examining and grading are all the responsibility of the chief resident.

The junior and senior teaching load varies but the chief resident continually assists the staff men responsible for teaching these groups in assignment of students, grading, orientation and supervision of the program at the "grass roots" level. In addition, the chief resident is available to substitute for assigned teachers in the event they cannot keep commitments and thus may give lectures or conduct rounds or seminars. He also gives assigned lectures to the senior students in the Emergency Room.

A brief "History of Surgery" course is given for the junior students every quarter. The chief

resident delivers the initial and concluding lectures as well as supervises the remaining six or eight lectures.

The chief resident has no fixed assignment as far as nursing personnel teaching is concerned. However, he gives about six lectures or talks per month and during the year will lecture to graduate nurses (head, operating room, general duty), practical nurses, and student nurses. In addition he will deliver an occasional talk outside the hospital usually to nonprofessional groups.

Conferences

There are certain established functions which the surgical staff is required to attend. The chief resident maintains attendance at these functions.

- Surgical Pathology Conference during which gross and microscopic specimens are presented by the surgical pathologist. The chief resident helps arrange these sessions (weekly).

- Clinical Pathological Conference run by the department of pathology; discussants are assigned by the chairmen of the various departments. Each surgical intern and resident submits a diagnosis on the current C.P.C. (weekly) to the chief resident the

day of the conference and then all attend.

- Tumor Conference, Mortality Conference, Grand Rounds. These three conferences are held each Saturday from 9-11 A.M.

On Thursday afternoon, residents in charge of services gather in the chief resident's office and submit patients for discussion at the Tumor Conference. From these, two or three are selected, a brief history obtained and a program printed for the Saturday conference.

At this meeting the deaths for the preceding week are placed in order according to general interest, presence or absence of an autopsy, and perhaps service on which the death occurred. These are then presented and discussed on Saturday mornings.

Lastly, inpatient cases are presented for Grand Rounds by the various residents; these are discussed, and three or four case records selected for presentation, again a short history is obtained and a program printed.

It is the chief resident's responsibility to see that the proper non-surgical services are notified (x-ray, pathology, anesthesia, etc.) and that the patients are transported to the conference. He serves as "master of ceremonies" throughout all these conferences.

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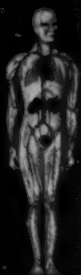
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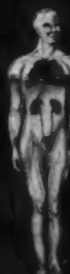
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Records

The chief resident is responsible for all patient records and other departmental records. Every Sunday morning he conducts History Meeting, which is attended by all interns on surgery and residents. All charts of patients discharged the previous week are presented for review as to content and completeness. Since this means 150-200 charts, the chief resident relies heavily on the various senior residents, but will often check each chart.

At this time, announcements, criticism, or suggestions are passed on to the surgical staff, complaints are heard, and problems settled. No staff person attends this session without previous invitation (except the department chairman) and it is from this meeting and the Thursday meeting that the house staff is administered.

In addition to the charts, the department maintains certain records regarding special spheres of interest (such as spleen surgery). These are assigned by the chief resident and he follows their preparation closely.

Perhaps the largest "paper work" problem has to do with the collection of statistics. Each month, the responsible residents, general and special, submit a

monthly report. This contains information as to: total discharges, operations, complications, death, autopsies, and individual operative experience. This is checked for accuracy and completeness. In addition to statistical value it is used as a basis for rotations and service set-ups.

From this monthly data, the chief resident compiles the annual report of the department. Of course, to this material, he adds publications, various departmental activities, appointments, resignations, and in addition adds similar material from Children's Hospital, The Veteran's Administration Hospital in Dayton, and the other components.

Other duties

There are a number of smaller assignments that the chief resident is responsible for:

- See all general surgery consultations.
- Collect autopsy percentages of the various services and report monthly at Grand Rounds.
- Maintain autopsy rate at 80 percent.
- Assist the chairman of the department with the enrollment of all the residents in the graduate school, attendance of the residents, and maintain records for grades.

• Supervise residents who contribute to the anatomy course in the Medical School, make all arrangements with that department; see that commitments are filled.

• Maintain 40 percent blood replacement level at all times.

• Act as consultant to the Veteran's Admission Hospital; visit two or three times a month.

• Handle insurance forms, disability claims, proof of death forms and other papers referring to patient care.

• Serve ex-officio on the Intern Selection Committee, interview interns, conduct tours of the Hospital, report on applicants.

• As member of Residency Committee, help pass on promotion of residents from one year

to the next, act on resident applications, interview applicants.

• Attend various meetings (such as American College of Surgeons, American Medical Association, etc.) and present papers at these meetings.

• Conduct own research program, publish at least one paper during year as chief resident.

• Complete at least the first part of the Boards in surgery.

The overall picture: continuously on call, beset by a myriad of problems, both patient and administrative, thanked by few and blamed by many, the chief resident is a busy, harassed person. Yet the job is worth it—and remains a highly coveted position.

STRONG MEMORIAL HOSPITAL

Harold W. Bales, M.D.

The responsibilities of the chief resident in surgery may be considered under two categories; direct patient care, and the administration of many aspects of the surgical department. The latter role is a challenging and valuable

experience which should be an integral part of a surgeon's training. It is here, more than in earlier years of residency, that he prepares himself through practical experience to implement good patient care, good teaching, and

After serving in the Infantry during World War II, Dr. Bales attended Colgate University and was graduated from the University of Rochester School of Medicine and Dentistry in 1952. Entering the surgical residency program at Strong Memorial Hospital, he completed his training as chief resident in surgery.

a satisfactory professional relationship.

Before discussing the details of our departmental program a brief description is in order. Our house staff is organized at the usual three levels—intern, assistant resident, chief resident.

The chief resident is of course the most senior house officer and occupies a position analogous to the chief of service. The chief residency appointment in our hospital is for a one year period. We have two residents at a time, one the chief resident and the other an associate resident. Every six months one man finishes and another starts. We have found that such a staggered succession makes for a smooth changeover. Both work closely together, alternating night calls and sharing staff operative work. In addition, the chief resident assumes the administrative duties and follows the professor's private patients. He works closely with the professor, meeting with him daily to discuss departmental problems.

Teams

As far as is possible the house staff works in teams of two, an intern and an assistant resident assigned to a group of private surgeons or to the staff service. The chief resident and associate resident are the counterparts on the staff service of the private surgeons on the private service. Assignments of assistant residents are for three or six month periods, the interns for one month periods.

Each team assumes active responsibility for the pre- and post-operative care of the patients on their service under guidance of the attending surgeon.

Coordinator

The chief resident, since he participates in all aspects of the department's functions, is in many respects a coordinator of departmental activities. Primary administrative responsibility is toward the house staff supervising their work, arranging the teaching program and seeing to their well being. In addition he

arranges rounds for the staff medical students and nurses, manages the operating schedule, and represents the department in many of the day to day problems with the nursing service, record room, admitting office and other departments.

Experience

The basis of the house staff teaching program lies in case experience. To the intern is delegated the primary responsibility for pre- and postoperative care. We make daily ward rounds with the interns and assistant residents on their own patients, outlining the general plan of management for each and discussing the problem cases in detail.

As a junior house officer progresses in experience and capability he is allowed to assume increasing responsibility in the management of his patients.

Operative experience is similarly obtained on a graded basis, assignments being made by the chief resident according to the ability of the house officer. When an intern has satisfactorily mastered the basic surgical techniques, he begins doing appendices, herniorrhaphies, amputations and similar procedures assisted by either the chief resident or a junior attending man. Simi-

larly the assistant resident advances his experience doing more major procedures with senior assistance and minor procedures on his own to foster judgment.

We have several more formal exercises for the house staff at scheduled times during the week. One of the more popular has been a weekly supper meeting held each Tuesday in the hospital dining room. One meeting a month is devoted to a discussion of complications from the preceding month. Case records for review are selected in advance by the resident and a senior attending who moderates the meeting. These sessions have proved very valuable in bringing forth discussion of surgical problems in general.

At the remaining meetings we may have a guest speaker on a surgical topic, surgical movies, reports on national meetings, etc. The first portion of each of these meetings is used by the resident as a staff meeting.

One afternoon a week the resident and a senior attending hold clinical rounds for the house staff known as Walking Rounds. Two or three staff cases selected as problems in diagnosis and management, unusual disease entities or patients illustrative of more common problems are presented

for discussion. The tone has been informal and all present are encouraged to participate.

A surgical pathology conference is held on alternate weeks with an x-ray conference. Material for both is selected from current hospital cases.

Instruction

The resident staff plays an important role in medical student teaching, assuming responsibility for informal instruction in day to day patient management. The resident and assistant residents review students' work-ups, make daily floor rounds and instruct in operating procedure. A member of the senior attending staff meets with the students at scheduled times for more formal rounds. Patients for these sessions are selected by the resident to illustrate specific surgical problems.

Schedule

The resident makes out the operating schedule each day assigning the teams. Private surgeons have an assistant resident as first assistant, an intern as second assistant. The two assistants are usually the team that also participates in the pre- and post-operative care.

The chief resident is directly

responsible for the surgery on all staff cases. Assignment of house officers to do the surgery is made on a graded basis according to the individual's experience and capabilities. Elective operations are scheduled with the Anesthesia Department ahead of time.

Allowing for operating priority of certain of the senior attending staff, the order of cases is determined on the preceding day. One room is reserved for "dirty" cases—open bowel surgery, gangulating wounds, etc. Emergencies are scheduled with the resident. At night when operating facilities are limited the resident decides which patients take precedence in event of conflict.

Communication

In a large hospital the house officer may feel that he is just another employee without any voice in policies or any direct contact with the administration. During the past several years we have developed a relationship with the administration which has been of benefit to all. Once a month the chief residents of all services meet with the hospital administrators to explore common problems. Through these meetings we have been able to introduce a number of desirable changes in the hospital and be-

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come informed on hospital administrative decisions.

A representative of this group sits with the Associate Hospital Committee—a committee of senior attendings. Representatives of other hospital groups such as head nurses, dietitians, etc., are invited to attend when problems relating to their departments are on the agenda. Each chief resident submits topics to the agenda which he or other members of his house staff feel warrant consideration by the group. While this group meets in an advisory capacity only and has no authority of its own, it has been responsible for initiating many policies.

Duty

In keeping with the general policy of graded responsibility each group, assistant resident and intern, makes out its own night duty schedules subject to the approval of the chief resident. Assistant residents have less formal night duty; two are on call each night, one in the Emergency Room and one for inpatients.

Every house officer is expected to make daily rounds on all his patients and perform the indicated daily care. The principal function of the "on call" man is to deal with situations arising during the night.

Each intern and resident is entitled to two weeks vacation during the year. The chief resident schedules vacations at the individual's request. The only stipulations:

- No vacations in June due to the annual changeover in house staff.
- No more than one intern may be absent at a time.

We have included a "float" in the interns' rotation to cover during illness and vacation periods. This man, when he is not otherwise occupied, fills in at the clinic.

Grand rounds

Grand Rounds for the entire staff are held once a week with the professor presiding. It is the chief resident's duty to select cases, arrange for presentation of x-ray and pathological specimens, and to invite appropriate members of other departments to contribute to the discussion. Usually three cases are presented in one hour. Cases are chosen from current hospital material which are of general interest.

Records

Hospital records are primarily the responsibility of the house staff. This includes the writing of histories and physical examinations, progress notes, discharge

summaries, and coding of diagnosis.

At the end of each week the chief resident reviews all the discharge charts for accuracy and completeness. In addition, it is his responsibility to keep the statistics on operative procedures and to review the month's complications. As mentioned elsewhere, the most interesting complications are then selected for discussion.

Personal

From time to time personal problems arise with house officers. Since the chief resident has a primary responsibility toward the morale and well being of the house staff, it is emphasized at the beginning of each year that the chief resident is available to help with any housing or financial problems. These are fairly common among house staff members and the resident is often in a

position to at least expedite a solution.

Fortunately, discipline problems are rare. When such matters do arise they are first discussed with the chief of service and with his approval settled directly by the chief resident. Almost always a direct discussion with the persons involved is sufficient.

I have touched upon only the more common administrative problems here. Needless to say there are a multitude of lesser day to day problems which are either settled directly by the chief resident or cleared through him. The smooth management of this aspect of the residency requires a thorough personal knowledge of local ground rules, customs, precedents, personalities and other intangible factors. With such a background, the administrative duties of a residency can be as rewarding and satisfying as the clinical side.

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There are laws limiting the period of time in which a patient can take legal action against you. In malpractice suits, most states have a two year statute of limitations. Here are some important facts you should know about . . .

... The Time Limit On Malpractice Suits

Every state has laws which limit the period of time in which legal action can be brought. Called statutes of limitations, these laws are of interest to the physician in connection with malpractice and breach of contract claims.

The time limits for different types of actions vary within each state as well as from state to state. In the same state, a breach of contract may have a six year statute of limitations while an action for personal injuries may have to be started within two years.

For the most part, *statutes of limitations on malpractice vary from one to three years.*¹ In one jurisdiction — South Carolina — the time limit is six years.

However, provision is usually

made in the statute for postponement, suspension, or extension of the time limit in certain instances, such as fraudulent concealment of the injury. This aspect will be discussed later in the article.

Georgia and a few other states have no statute of limitations specifically applicable to malpractice. Malpractice actions in those states come within the statutes specifying time limits on actions for personal injuries.



Purpose

The purpose of a statute of limitations is:

- to guard against difficulties of securing evidence to litigate what is called a "stale claim"
- to enable a defendant to feel secure "in his reasonable expectation that the slate has been wiped clean of ancient obligations."

In actions to recover damages for personal injury, among which malpractice actions are included, the evidence usually is of a type that is perishable. A short statute of limitations in such cases thus facilitates determination of the validity of the claim.

On the negative side, however, accurate evaluation of the extent of injuries is difficult in many cases since permanent injury or further damages may continue to develop after the law suit has ended. Prospective damages are often difficult to determine.

Whether the court tries to find exceptions to the statute of limitations or chooses to apply it strictly will depend on its point of view. For example, one court, in summing up the purpose of the statute of limitations, said that a defendant should not have to defend a claim when "evidence

has been lost, memories have faded, and witnesses have disappeared."²

A Missouri plaintiff underwent an operation for a diseased gall bladder. Surgeon failed to remove the gall bladder, removing a kidney instead.

The Missouri statute of limitations for malpractice was two years but for actions on a contract six years was the limitation period. More than two years after the operation plaintiff sued surgeon, alleging defendant had breached his contract with patient to remove the gall bladder.

Which statute applies?

The action was dismissed. The court held the gist of the wrong complained of was malpractice and that the shorter statute applied.³

Most jurisdictions agree with the Missouri court that an action for damages for personal injuries arising out of a physician's negligence is one of malpractice.

In some instances, however, in order to avoid the shorter statute, courts have allowed the contract theory to prevail.

A case in point is *Keating v. Perkins*.⁴ Patient visited the dentist to have four teeth extracted, including one tooth with a gold inlay. Surgeon dentist

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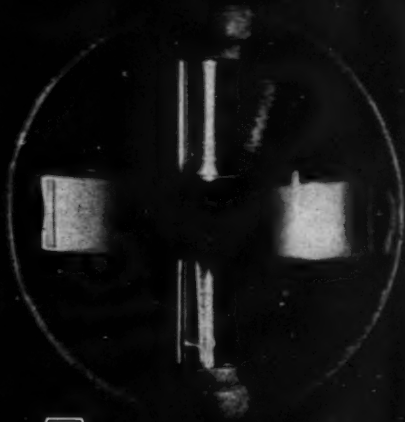
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List of References 1-20 supplied on request.



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failed to remove the tooth with a gold inlay. The court held the contract to remove each and every part of the four teeth from plaintiff's mouth was breached; the degree of care exercised by defendant was immaterial.

Actions for breach of contract are limited since such actions must be based on a specific promise, agreement or warranty, as for example the removal of certain teeth, or a certain part of the body such as the appendix.

Timetable

In general, the statute begins to run from the date of the wrongful act or omission rather than from the date the resulting damage develops, or the date patient discovers the injury. Illustrative of this rule is a 1940 Connecticut case.

Defendant doctor was summoned by an obstetrician to give the latter's patient a transfusion. Defendant did not test donor's blood for syphilis. Eight months later patient discovered she had syphilis. Although she was treated for syphilis by defendant, she died one week later.

More than one and a half years after death, but more than two years after the negligent transfusion, the action was started.

The two year statute of limitations barred the action.⁵ The wrongful action was the negligent transfusion. When this occurred, the statute started running.

Wrongful act

Defendant dentist left a portion of a root of a tooth in plaintiff's gum when extracting a tooth. Nearly two years from the date of the extraction plaintiff first began to suffer ill effects, and upon consulting another dentist, the presence of the root was discovered. Legal action was not commenced until three years after the original extraction.

Plaintiff's action began too late for recovery of damages. The court emphasized that the original wrongful act makes out the cause of action. Later injurious developments are elements of damages which may be recovered. The wrongful act, not the damage sustained, is the cause of action.⁶

One court emphasized that the damages may be nominal at the time of the original wrongful act or omission, and that consequential damages resulting from it might be substantial and not foreseen. But the court said this did not change the rule that the right to legal action began at the earlier time.

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Situation

The fact that the plaintiff was unaware of the existence or extent of his injuries or of his right to a cause of action for malpractice is immaterial and does not postpone the commencement of the limitation period.

It has been argued that to toll (suspend) the running of the statute until the injury and its cause and effect are fully discovered would lead to an intolerable situation:

"Recognition . . . of (such a) rule would permit a plaintiff, affected with some malady, to trace that malady to an original cause alleged to have occurred years and years ago. No practicing physician . . . would ever be safe. The origin of disease is involved in uncertainty at best. While hardships may arise in particular cases by reason of this ruling, a contrary ruling would be inimical to the repose of society and (would) promote litigation of a character too uncertain and too speculative to be encouraged."⁷

In many instances hardships to patients result from the application of this rule. It precludes legal recovery in many cases in which, from the nature of the malpractice, the patient does not have any information on which to

bring suit within the time allowed, or cannot possibly know that the cause of action exists.

Certain exceptions to the general rule have therefore developed, namely: cases of continuing treatment; cases involving foreign objects; cases of fraudulent concealment, and, in some instances, constructive fraud. Note must also be made here of the discovery rule which operates in California and Louisiana.

Continuance of treatment

The mere fact that the course of treatment continues after a single act of negligence does not postpone the running of the statute. If the injury is complete at the time of the act, the statutory period begins to run at that time.

An example of this is the case previously discussed, in which a blood transfusion was negligently administered. The statute started running at the time of the negligent transfusion, not when the course of treatment ended.

But where the injurious consequences arise from a course of treatment, the statute does not begin to run until the treatment is terminated.

Patient was suffering from glaucoma in both eyes. For

more than a year he visited defendant who negligently failed to diagnose his condition by failing to test for glaucoma.

Three months before treatment ceased, plaintiff became totally blind in his right eye. The court held the statute of limitations began to run at the time the treatment was terminated. The malpractice continued throughout the course of treatment.⁸

Defendant, a plastic surgeon, operated on plaintiff in August 1946, to remove an enlargement or hump on the bridge of her nose and to reduce the length of the nose. Several weeks later, while still under defendant's care, keloids and adhesions appeared at the site of the recent operation, causing a very "bumpy and irregular shaped nose."

Defendant then performed a second operation to remove the keloids and adhesions.

More extensive keloids and adhesions appeared after the second operation, and plaintiff could not breathe through one nostril. In October a third operation, at which defendant was present, was performed by another specialist upon defendant's advice. Thereafter plaintiff continued to visit defendant at his office two or three times a week for treatment.

A large keloid reappeared on

the left side of plaintiff's nose, and defendant referred plaintiff to an x-ray specialist for treatments. These treatments were moderately successful in improving plaintiff's condition, although at the time of the trial there was still a disfiguring scar on the right side of plaintiff's nose and her ability to breathe properly was impaired.

Suit barred

Plaintiff continued to visit defendant until November 1947.

Plaintiff started legal action in January 1949, in New Jersey, which has a two year limitation period. Plaintiff argued that the statute of limitations begins to run where the course of treatment ends. The court held that the statute begins to run not at the time the course of treatment ends but when the last negligent act is performed.

The negligent acts complained of here were those which occurred during the operations and later, delay in advising x-ray treatments. There was no evidence of negligence after x-ray treatments were begun in December of 1946. The action was barred by the statute of limitations.⁹

A few jurisdictions accept the view argued by plaintiff in the

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To eliminate anorectal pain and itching during pregnancy, *start* treatment with anti-inflammatory Anusol-HC Suppositories for 3 to 6 days. Then *maintain* patient comfort with regular Anusol Hemorrhoidal Suppositories. Neither preparation contains narcotics nor analgesics, therefore they will not mask more serious rectal pathology.

And for constipation . . . either alone or concurrent with anorectal disorders . . . prescribe pleasant-tasting Agoral (described next page).



WARRIS PLAINS, N.J.

above case. It is the minority rule that if malpractice occurs at any time during the course of treatment the statute does not run until the entire treatment ceases.

Foreign objects

Surgeon failed to remove a rubber drainage tube from patient's abdomen after it had served its purpose. Plaintiff continued under his care and treatment for almost two years, until defendant reoperated and removed the drainage tube. All during this period plaintiff was unaware of the presence of the tube or the cause of failure to recover from first operation.

The court took the view that this was a case of continuing negligent treatment which did not end until the tube was removed from the body.¹⁰ Courts vary in their decisions on similar fact situations.

Normally, knowledge of the injury by the plaintiff is not a factor in determining when the statutory period starts. Defendant left an arterial forceps in plaintiff's abdominal cavity after removing an appendix. Plaintiff felt unwell after the operation but various physicians whom she consulted, including defendant, assured her of the success of the appendectomy.

More than two years after the operation another physician discovered the presence of the forceps. Legal action was barred by the two year limitations statute.¹¹

California and Louisiana are unique in adopting the rule that the cause of action accrues when plaintiff discovers the injury. The theory of the courts in these jurisdictions is that a cause of action should not be barred where plaintiff could not know it existed. While the rule originally began in California in cases where foreign objects were left in the body, it has been since extended to all malpractice cases of that state.

Fraudulent concealment

If a physician performs an act of negligence or malpractice and knowingly conceals the fact from the patient, the statute of limitations does not begin to run until the injured party discovers, or through exercise of reasonable diligence should have discovered, the negligent act.

The elements of fraudulent concealment are:

- actual knowledge of the negligent act on the part of the physician
- an affirmative act to conceal the facts from patient, or

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Agoral provides the safe, gentle laxative action so desirable in overcoming the constipation of pregnancy. Taken at bedtime, 1 or 2 tablespoonfuls of pleasant-tasting Agoral work overnight, without disturbing sleep, to produce a normal bowel movement next morning. Agoral encourages *natural* bowel function . . . without harsh cathartic action . . . without urgency . . . without anal leakage.

And for hemorrhoids . . . either alone or concurrent with constipation . . . prescribe Anusol and Anusol-HC suppositories (described preceding page).



mere silence, or failure to disclose the facts

- a fixed purpose to deceive
- patient - physician relationship

If any of these elements is missing, fraud is absent and the statute is not suspended.

The theory behind this exception to the general rule is that a confidential relationship exists between the physician and the patient which imposes a duty upon the physician to disclose to the patient the nature and character of any treatments he has performed on patient.

During the course of an operation surgeon negligently left a sponge in patient's abdomen. Subsequently he realized his mistake, but when approached by patient complaining of pain and discomfort he assured patient that the pains were merely routine. The discomfort continued but surgeon continuously reassured patient until the lapse of the statute of limitations. Thereafter patient discovered the presence of the sponge. These facts spelled out a case of fraudulent concealment.¹² It was not incumbent on patient to consult another physician. He was entitled to rely on the performing surgeon's reassurances.

A few jurisdictions, including

Arizona and Colorado, have eliminated knowledge of the negligent act by the physician as a necessary element of fraudulent concealment. It is sufficient in these jurisdictions that the negligent act by the physician as a necessary element of fraudulent concealment. It is sufficient in these jurisdictions that the negligent act be such that a reasonably diligent physician *ought to have known* of it.

Constructive fraud

In a 1948 Arizona case, physician's drill broke during an operation. The court indicated that the defendant physician, by the exercise of reasonable diligence, ought to have known that a piece of the drill was missing.

Since good medical practice would require him to take x-rays to locate the broken drill and remove it, failure to notify patient of his omission constituted "constructive fraud" regardless of intent to defraud.¹³

Tolling of statute

The statute is tolled (postponed or suspended) while defendant is outside the jurisdiction and cannot be served; during an infant's minority (under 21 in most jurisdictions). In some states insanity of plaintiff also

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suspends the running of the statute.

However, a plaintiff can be barred from suing if he delays suit for an unconscionable time without cause. A four-year-old patient developed a pink mark on her forehead which defendant erroneously diagnosed as a birthmark instead of scleroderma.

Twelve years later patient's guardians sued on her behalf, alleging erroneous diagnosis and radium burns from x-ray treatment of the supposed birthmarks.

In holding the weight of evidence in favor of defendant the court said:

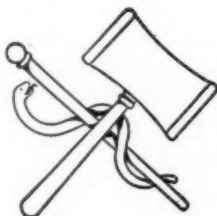
"While the statute of limitations would not run against plaintiff during her minority we are nevertheless of the opinion that a just appraisal of the testimony of her guardians requires the court to consider the fact that with full knowledge of the facts, they delayed filing this action for twelve years.

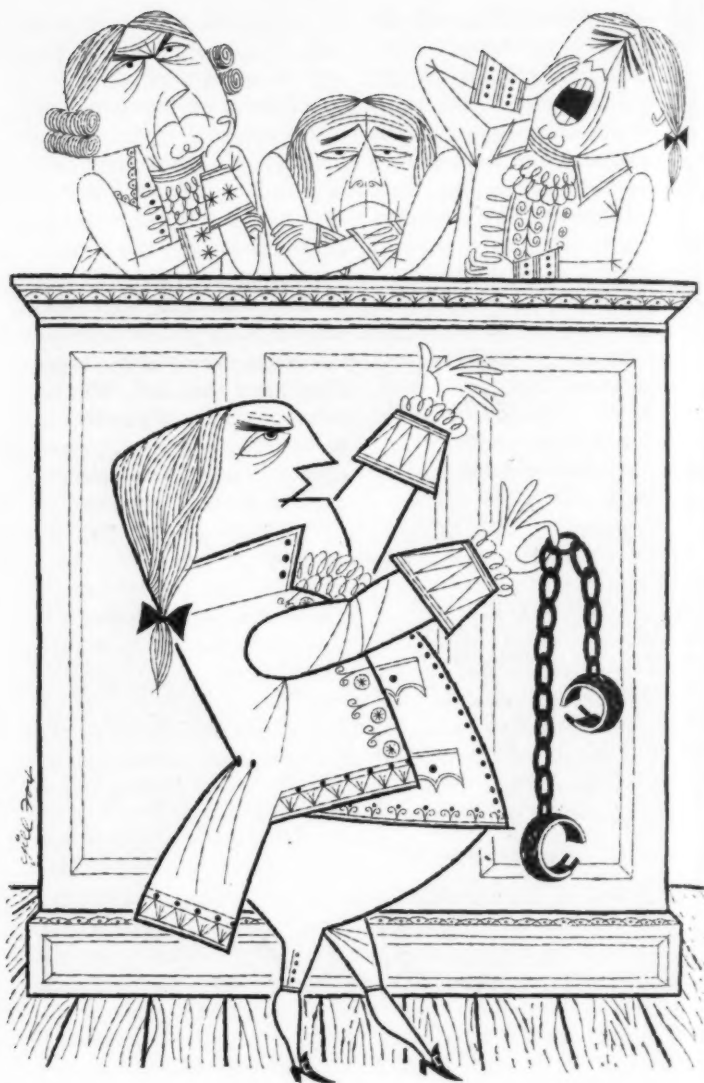
"Her custodians were adults. They had the power to institute this action during all those years. They knew the facts. Why such delay? Aggrieved persons ordinarily do not postpone asserting rights so long. We consider that in reaching our conclusion."

References

1. A one year malpractice statute of limitations exists in Ala., Calif., Conn., Del., Ky., La., Ohio, Tenn., W. Va., and Wyo. Two year statute: Ariz., Colo., Ga., Ida., Ill., Ind., La., Kan., Mass., Mich., Minn., Mo., Neb., N. H., N. J., N. Y., N. Dak., Okla., Ore., Pa., R. I., Nev., S. Dak., Tex., and Wis. Three year statute: Ark., D. C., Fla., Md., Mont., New Mex., N. C., Va., and Wash.
2. Order of R. R. Telegraphers v. Railway Express Agency, Inc., 321 US 342, 349 (1944).
3. Barnhoff v. Aldridge 38 S.W.2d 1029 (1931).
4. 250 A.D. 9, 293 N.Y.S. 197 (1937).
5. Giambozi v. Peters, 127 Conn. 380, 16 A2d 833.
6. Albert v. Sherman 167 Tenn. 133, 67 S.D.2d

- 140 (1934).
7. Albert v. Sherman, supra footnote 6, at p. 142.
8. Shives v. Chamberlain 126 P2d 28 (1942).
9. Tortorello v. Reinfeld 6 N.J. 58, 77 A2d 240 (1950).
10. Huysman v. Kirsch 6 Cal 2d 302, 57 P2d 908 (1936).
11. Conklin v. Draper, 229 A.D. 227 (1930), affirmed without opinion 245 N.Y. 620, 173 N.E. 892 (1930).
12. Baker v. Hendrix 126 W.Va. 37, 27 SE 2d 275 (1943).
13. Morrison v. Acton 68 Ariz. 27, 198 P2d 590.
14. Hubach v. Cole 31 N.E. 2d 736 (Ohio, 1939).





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The Doctor Who Cared

Fighting for his beliefs nearly cost this physician his life. But his leadership freed untold thousands and set a humane pattern for care of the mentally ill.

Edward R. Bloomquist, M.D.

By the time of the French Revolution, Paris physicians had justly won a world-wide reputation for contributions in diagnosis and treatment of organic disease; but in the field of psychiatry, they were in a vacuum of ignorance.

In Eighteenth Century France, there may have been doctors who believed that mental illness deserved the same study, sympathy and care as physical sickness. But these doctors were the few. This fact became obvious to Dr. Phillipe Pinel, newly appointed director of Bicêtre, prison-hospital of Paris, as he had his first look at the facilities and patients he was to supervise.

Rubbish and excreta covered the floors and dark halls. In box-

like cells, inmates awaited death from disease, mistreatment or boredom.

Some were shackled to the wall, others held by iron collars or waist hoops. Those who could lie down on damp, knotty straw pallets were tortured by the cruel manacles at their extremities.

Each cubbyhole possessed but one barred opening, so small that neither sunlight nor fresh air ever touched the imprisoned men. Except for feeding time, when stale bread and watery gruel were thrust through the grill by keepers, Bicêtre's patients had no contact with the outside world.

This concludes the story of Dr. Pinel which began as "A Time for Compassion" in last month's issue.

As far as the citizens of France were concerned, the insane were dead.

Prisons

In Paris, Bicêtre and its companion hospital Salpêtrière were prisons in the worst sense of the word. Unbelievable brutality was inflicted upon patients. They were considered to be and treated like wild beasts.

Three diagnoses existed for these unfortunates. If wild, they were restrained and classified as maniacs. Those who wept in the depression of their hopelessness were termed melancholiacs. The little extra freedom permitted them went unappreciated for they were too unhappy to care. The third group were less restricted, but equally despised because of their confusion. Their diagnosis: dementia.

Rest and understanding

Pussin, the head keeper of Bicêtre was an uneducated, crude, but honest individual. It was he who guided Pinel through the dungeons, gave him his initiation to Bicêtre.

Appalled by what he saw, Pinel appealed to the head keeper for assistance in revising this pathetic situation. His pleas fell upon friendly ears, for Pussin

was as disgusted with conditions around him as the new director. His position and education, however, had prevented him from doing much about his beliefs.

With Pussin's help Pinel started examining the patients and records were begun which listed their diagnoses and reactions. Any indication of possible recovery was carefully researched.

Although shackled by the public's stupidity, ignorance and bias, Pinel began to treat his charges. He utilized rest, quiet and understanding in patient management. He reduced and finally eliminated the despised purgings, blisterings and bleedings so popular at the time.

The manacles, however, stayed on. The physical condition of the prison did not change, and Pinel, up to this time, was not permitted to exercise authority which could alter the situation.

Trio

To obtain this authority he applied for an audience before the Commune. Tersely he outlined his plan to strike the chains and allow reasonable freedom within the prison to qualified patients.

His pleas were ignored at first, but he was insistent, convinced of the importance of his project.

Unfortunately, he was talking to a trio of judges who in their own way were mentally worse off than his inmates. Obsessed with the importance of ridding the earth of Royalty, they listened coldly to Pinel, granting him audience only because his reputation and influential friends left them with no alternative. They would have killed him had they dared for they suspected him, possibly with justification, of hiding Royalist sympathizers among his madmen.

These three judges, Robespierre, Saint Just and Couthon, were well matched. The first seemed determined to vent his wrath upon a world which had permitted him to mature without parental sympathy and in an atmosphere abounding with delinquent association. Saint Just was a sadist. Impulsive, ambitious, he stood ready to slide into prominence on the blood of innocent victims.

Then there was Couthon. It was this man, crippled, filled with resentment because of his deformity, whom Pinel finally managed to impress—but not because of any deep humanitarian interest on the part of Couthon. At the proper moment, Pinel had disrobed Citizen Couthon's ego,

ushered it into the public eye and placed it uncomfortably beneath a Damoclean sword.

Argument

"Does not Citizen Couthon believe in 'Liberté, Égalité and Fraternité?'" Pinel inquired.

The magistrate strenuously affirmed his belief, for it was upon his support of this triad of freedoms that Couthon had established his reputation.

Pinning him with righteous indignation, Pinel then inquired why these rights were not permitted citizens in Bicêtre and Salpêtrière. Couthon wiggled his deformed body uncomfortably, for Pinel, intent upon his subject, was boldly exposing a point that was political dynamite. And with all reticence and shyness gone, Pinel fought for his patients.

"These people are citizens of France, Monsieur Couthon," he cried, "deserving kindness and reasonable liberty—yet they suffer in conditions far worse than those formerly experienced by Frenchmen under the thumbs of the Aristocrats."

The trio, confused, conferred among themselves. Ending their whispered discussion, they tried to turn the conversation to the subject of Pinel's alleged Royalist sympathies.

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Ampuls, 1 ml. (5 mg.); cartons of 5.

I. Rhano, S. J., Krayak, T. K., and Copp, S. E.: *Canad. M. A. J.* 77:600 (Sept. 15) 1957.

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But Pinel stood firm, realizing he had sliced at Couthon's ego, knowing Couthon would not permit any questionable remarks to remain unanswered if they attacked his highly touted stand on equality for all men.

Visit

"I will come to Bicêtre and see for myself," Couthon finally decided. "But Citizen," he remarked as an afterthought, "if thou has deceived us and concealed enemies of the people among thy madmen, woe to thee!"

Early the following morning, Couthon limped through the gates of Bicêtre. Hobbling into the dismal, humid darkness, trying to maintain his balance as his shoes slipped on the filth beneath his feet, flinching from the noise and attempts at physical violence by the inmates, he hurriedly finished his tour.

Ill and shaken, Couthon lurched into the fresh air of the prison exit. Turning to Pinel, he said hoarsely, "Citizen, you are crazy to want to unchain such beasts!"

Pinel was numb as Couthon turned a disdainful glance at the misery behind him and limped quickly toward his carriage. Then, Couthon stopped. He

turned with a thoughtful look at Pinel, nodded sardonically. "Do as you will, but your own life will be sacrificed to this false mercy."

Last obstacle

As Couthon's carriage rumbled down the cobblestone streets, it took with it the last obstacle to Pinel's plans. Enlisting Pussin's help he began combing the patient list. He made a careful selection of those he felt could be safely released from their chains. When he finished, he had accumulated more than 50 names.

Pinel was not an incompetent do-gooder. He had no intention of risking his program because of inadequate preparation. To circumvent trouble, he ordered twelve straight waist coats prepared, each reaching below the knees. Long sleeves permitted the arms to be tied around the chest if restraint became necessary. From his patient list he chose a dozen men. Then, accompanied by a retinue of keepers and interested personnel, he descended into the dungeon and approached his first candidate.

It was difficult to see the miserable creature chained in the dimly lighted cell. Once he had been a proud English Captain, but years of incarceration and

mistreatment had caused him to become sullen and withdrawn. On the few occasions he was heard to speak, he sounded irrational. Because he had killed a keeper, undoubtedly with provocation, he was considered a maximum security patient; from the day of the keeper's death he had been ignored as much as possible.

Too afraid

As spectators and guards crowded around, holding their torches high, Pinel carefully approached the captain. Holding his attention with quiet conversation, the doctor tried to dispel apprehension. When the patient appeared receptive, Pinel explained the waist coat and offered him freedom from his chains in exchange for a promise of good behavior.

It was obvious to observers that the captain was trying to understand but such a torrent of thoughts must have collided with each other in the tormented man's mind, that there was utter silence for a long minute. Finally, the captain's lips opened and his seldom used voice crackled from the darkness.

"You're . . . laughing at me! You're too . . . too . . . much afraid of . . . of me to give me freedom!"

The captain sank against the wall. No sound was made by Pinel. In a moment, perhaps sparked by a small flame of hope, the captain slowly regained his feet and looked into Pinel's stern but sympathetic eyes. He must have sensed the presence of an honest desire to help. With slow deliberation, he nodded his leonine head.

"I will promise," he said.

But the effort of standing had been too much. He trembled and fell to the floor, settling among the chains which had bound him for over 40 years.

Rehabilitation

Pinel ordered his keepers to help him. Quickly they entered the cell and cast loose his chains. Helping him to stand, they fitted him with the waist coat and slowly helped him out into the courtyard. Forty years ago, he had known the blueness of the sky, then its beauty had slowly dissolved into a memory. Now, as he neared the exit, he could feel cool, fresh air as it blew against his face. A few steps farther and the long forgotten sky appeared before his sensitive eyes. Tottering about he touched, almost unbelievably, the bark of the courtyard trees. Bending, he inhaled the intoxicating scent of growing

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flowers. His eyes welled with tears.

"Oh," he cried, "how beautiful!"

He was taken to a clean cell equipped with a fresh straw mat.

Within two years this "hopeless" patient was discharged, and dozens of others had been given the same course of rehabilitation.

Under a program of kindness and understanding and minimal force, the most disturbed became manageable. Pinel's success soon brought him the position of Professor of Internal Pathology and Director at Salpêtrière, second of Paris' major asylum-prisons.

Many were unsympathetic toward Pinel's program. Some were violently opposed. One evening, some years after Pinel had begun his work, he was accosted in a narrow street leading to Bicêtre. The attempt to murder him might have succeeded had it not been for the intervention of a tall, muscular man whose military bearing and tactical ability soon dispersed the terrorists. He conducted Pinel to the safety of the hospital, pausing to look at the courtyard where, not too long ago, he had renewed his acquaintance with the sky. He watched, reminiscing, as the gates swung slowly shut, then quietly disappeared into the dusk of the Paris evening.

Teaching

Pinel reorganized his institutions and began teaching rounds. Physicians flocked to hear him. One of these was Esquirol who, under Pinel's influence, later developed a system of institutions which placed France in a position of leadership in psychiatric therapy.

Pinel was recognized as an outstanding clinician. For twenty years he was one of the most prominent faculty members of Paris' École de Médecine.

His interests were not limited to psychiatry, however, for even before he had begun his work with the insane he had become a highly esteemed nosographer with a particular interest in pathology. In 1798 he had published a two volume work *Nosographie Philosophique*, in which he attempted to align medicine with natural science. He hoped to assign diseases to various classes, orders and genera, trying to demonstrate that specific tissues were subject to certain disease. Although his investigations contained error he inspired his students to pursue the subject further.

In 1801 Pinel finished his *Traité Médico-Philosophie sur L'Aliénation Mentale ou la Manie* in which he discussed the origins of mental disease, showing that

many problems were secondary to pathological changes in the brain. A significant number of his ideas are still accepted and his methods of therapy have formed the basis for many current concepts in psychiatric treatment.

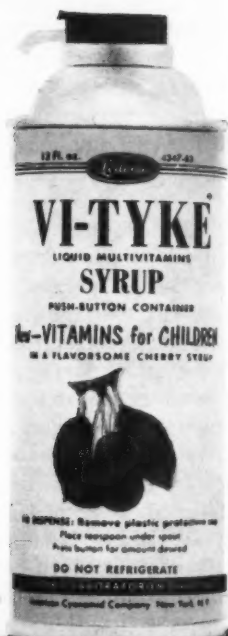
Unfortunately, the great are not immune to the workings of petty politicians. In Pinel's later years, the faculty at the École de Médecine was reorganized, and senior professors were quietly promoted to ineffective honorary positions. Pinel did not try to cope with this new trend. Snubbed by junior faculty associates he spent much of his time visiting the Bicêtre and Salpêtrière. It was at Salpêtrière on October 26, 1826, that Pinel died at the age of 81.

Even in death he was ignored by the Paris clinical school's faculty. It is doubtful, however, if there would have been room for them in the funeral cortege which followed the body of Phillipe Pinel to its resting place in Pere La Chaise. A sea of sorrowful, appreciative faces, many ex-

patients from Salpêtrière and Bicêtre, observed the final rites. Representatives from the Institute of the Academy of Medicine and the hospital-prisons, where Pinel had labored so effectively, pronounced his last eulogy.

The École de Médecine's faculty might never have been represented had it not been for Jean Cruveilhier. Standing half hidden among the crowd, this prominent anatomist waited until the others had finished. Then stepping respectfully to the graveside he spoke as a representative of the Paris faculty expressing sorrow at the loss of this benefactor and an appreciation for his monumental work.

The clouded skies of a new France looked down upon the quiet congregation of Pinel's former patients, fellow physicians and psychiatric assistants. Respectfully they attended this final resting place of a man singularly distinguished: in an era when most men were too preoccupied with their own affairs to be kind to one another, Dr. Phillipe Pinel found time for compassion.



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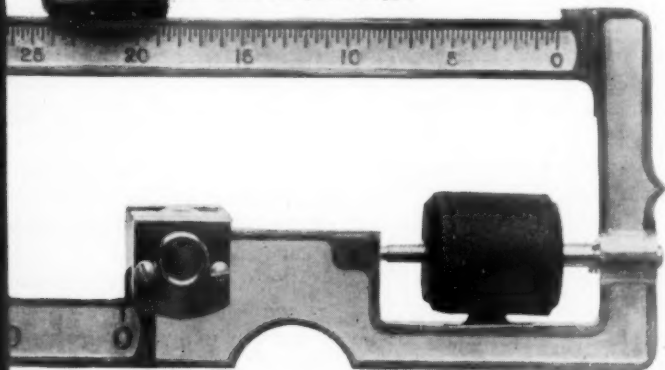
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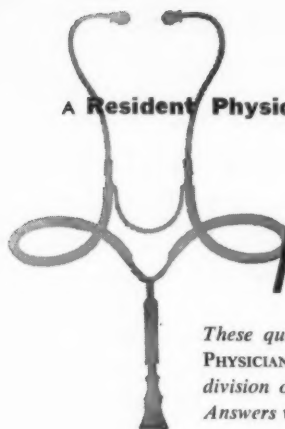
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A Resident Physician MONTHLY FEATURE

Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 194.

1. If it becomes therapeutically mandatory to administer tetanus antiserum prophylactically to a patient with a definite past history of allergic sensitivity to horse dander, and in whom routine skin and ophthalmic tests to horse serum are positive, the most reasonable procedure to avoid a dangerous serum reaction is to:

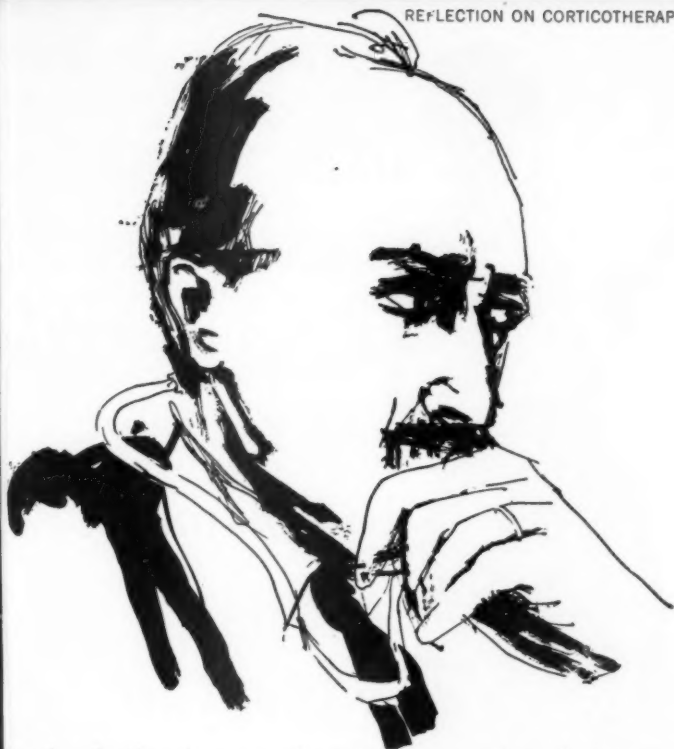
☒ A) Administer bovine antitetanic serum.

B) Dilute the ordinary antitetanic serum in 4 liters of normal saline and administer this very slowly by intravenous drip (not over 25 drops per minute), with constant attendance on the patient for adrenalin administration if necessary.

C) Start with 0.05 cc. of a 1 to 1,000 dilution of ordinary antitetanic serum, and give gradually increasing subcutaneous injections through 1 to 100 and 1 to 10 dilutions until undiluted antitetanic serum has been given subcutaneously. Twenty minutes should elapse between each injection. If no reaction has occurred, the remainder of the serum is given intramuscularly. Adrenalin is always at hand to protect against reaction.

D) Refuse to give antitetanic serum to a patient with a known sensitivity to horse serum regardless of the therapeutic emergency.

E) Dilute the ordinary antitetanic serum in 4 liters of normal



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case profile no. 3347* A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. The menarche had occurred at the age of 14. She was a gravida II, Para I. Her menstrual cycle was fairly regular, and a study of the medical history revealed no apparent abnormalities. Findings on pelvic examination gave negative results. Severe tension and irritability occurred routinely from two to even days before and during menstruation. Cramps were experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

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This patient has successfully remained on the above regimen for over six months without adverse effects.

Indications—Musculoskeletal: Low back pain (lumbago, sacroiliac pain, etc.); neck pain (torticollis); bursitis; rheumatoid arthritis; osteoarthritis; disc syndrome; fibrositis; ankle sprain; tennis elbow; myositis; postoperative muscle spasm. Psychogenic: Anxiety and tension states; dysmenorrhea; premenstrual tension; asthma; angina pectoris; alcoholism.

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*Clinical Report on file at the Department of Medical Research, Winthrop Laboratories.

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saline and administer by intravenous drip very slowly, not over 25 drops per minute. In addition give the patient $\frac{1}{2}$ cc. of 1 to 1,000 adrenalin just prior to the administration of the antitetanic serum and during the course of administration give $\frac{1}{4}$ cc. of adrenalin at hourly intervals.

2. What is the mechanism of action of hexamethonium?

- A) Parasympathomimetic.
- B) Adrenolytic.
- C) Parasympatholytic.
- D) Sympatholytic.
- ☒ E) Ganglionic blocking.

3. The loose bodies which develop in joints in osteochondritis dissecans are the result of a:

- A) Bacterial infection.
- B) Hypertrophic osteoarthritis.
- C) Rheumatoid arthritis.
- D) Congenital defect.
- ☒ E) Traumatic injury.

PSYCHIATRY

If you are interested in preparing questions in psychiatry for "Medi-quiz" or the Professional Examination Service, write for information to the Professional Examination Service, 1790 Broadway, New York 19, New York.

4. The direction of the displacement of the fragments following fractures of the middle phalanges depends upon the relation of the fracture to the insertion of the tendon of the:

- A) Flexor digitorum profundus.
- ☒ B) Flexor digitorum sublimis.
- ☒ C) Lumbrical muscles.
- D) Extensor digitorum sublimis.
- E) Dorsal interosseous.

5. Myositis ossificans is a complication *most* frequently following:

- ☒ A) Fractures about the elbow.
- ☒ B) Recurrent dislocation of the shoulder.
- C) Intracapsular fractures of the neck of the femur.
- D) Fractures about the knee.
- E) Fractures about the wrist.

6. The intracranial tumor most likely to be associated with a bony boss on the outer surface of the skull is:

- A) A spongioblastoma.
- ☒ B) An astrocytoma.
- ☒ C) A meningioma.
- D) An ependymoma.
- E) A medulloblastoma.

7. A fracture of the skull which passes through the groove of the

middle meningeal artery usually causes:

- A) Frontal lobe infarct.
- B) Pontine hemorrhage.
- ☒ C) Extradural hemorrhage.
- D) Subarachnoid hemorrhage.
- E) Cerebellar ataxia.

8. At the completion of the bassini hernioplasty the position of the spermatic cord is:

- ☒ A) Posterior to the internal oblique muscle.
- B) Anterior to the external oblique aponeurosis.
- ☒ C) Anterior to the internal oblique muscle.
- D) Between Scarpa's fascia and the external oblique aponeurosis.
- E) Between the transversalis fascia and the internal oblique muscle.

9. Splenectomy as a therapeutic procedure is most uniformly successful in:

- A) Idiopathic thrombocytopenic purpura.
- B) Cooley's anemia.
- C) Sickle cell anemia.
- D) Acquired hemolytic anemias.
- ☒ E) Congenital hemolytic jaundice.

10. The likelihood of postoperative development of tetany

after the resection of a parathyroid tumor is best correlated with:

- A) A low preoperative alkaline phosphatase.
- B) The degree of preoperative hypercalcemia.
- C) The age of the patient.
- ☒ D) The degree of preoperative bone disease.
- E) The degree of kidney damage.

11. Simple goiter is harmful to the individual *mainly* because of:

- A. Iodine lack.
- B. Fetal adenoma.
- C. Malignancy.
- D. Systemic toxicity.
- ☒ E. Local pressure.

Answers on page 194

REPRINTS AVAILABLE

Through the cooperation of the Professional Examination Service, Division of the American Public Health Association, special reprints of 150 Mediquiz questions and answers are now available in booklet form for \$1 per copy. To stimulate further study, the source of each answer is listed in the booklet. The supply of booklets is limited. To be certain you'll have a copy, send your dollar now to the Professional Examination Service, Department R-10, American Public Health Association, 1790 Broadway, New York City 19, N. Y.



What's the Doctor's Name?

He was born on August 31, 1821, at Potsdam, Germany, the eldest son of a school teacher. He attended the school and gymnasium there, and later studied medicine in the Friedrich Wilhelm Institute in Berlin.

His parents were not wealthy. But the Institute trained future military doctors for low tuition if they passed the entrance examination.

From 1843 to 1848 he was an army doctor in Potsdam. He was professor of physiology, first in Königsberg, then in Bonn and later in Heidelberg. In 1871 he occupied the chair of physics in Berlin and in 1887 added the post of director of the physiochemical institute at Charlottenburg near Berlin. He held these two positions until his death on September 8, 1894.

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...and his stomach
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He married when he was in Königsberg and upon the early death of his first wife remarried in Heidelberg.

His investigations occupied almost the whole field of science, from physiology to mechanics. His wide range of gifts included a rare aptitude for mathematics and the ability to deduce the presence of unknown natural phenomena from known. His epoch-making paper on the conservation of force was read to the Physical Society in Berlin in 1847.

In 1851, he invented the ophthalmoscope. He investigated the optical constants of the eye. With the aid of his invention, the ophthalmometer, he measured the curvatures of the crystalline lens for the near and far vision. He explained the mechanism of accommodations, discussed the phenomena of color vision. One of his greatest contributions was his attempt to account for our perceptions of the quality of sound. In the later years of his life he worked on the conservation of energy, hydrodynamics, theories of electricity, optics, meteorological physics.

Can you name this doctor?

Answer on page 194.

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VIEWBOX DIAGNOSIS

(from page 25)

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Note extensive strictures extending from the rectal tip up into the sigmoid with numerous fistulae.

MEDIQUIZ ANSWERS

(from page 186)

1 (A), 2 (E), 3 (E), 4 (B), 5 (A), 6 (C), 7 (C), 8 (C), 9 (E), 10 (D), 11 (E).

WHAT'S THE DOCTOR'S NAME?

(answer from page 192)

HERMANN HELMHOLTZ

RESIDENT RELAXER

(puzzle on page 29)

